SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Filing at a Glance

Company: National Health Insurance Company

Product Name: HSMPPO-2009P-AR	SERFF Tr Num: NHIC-126264594	State: Arkansas
TOI: H15G Group Health - Hospital/Surgical/Medical Expense	SERFF Status: Closed-Approved-Closed	State Tr Num: 43356
Sub-TOI: H15G.002 Large Group Only	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Banu Loyd	Disposition Date: 10/02/2009
	Date Submitted: 08/27/2009	Disposition Status: Approved-Closed
Implementation Date Requested: 10/01/2009		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Submitted as File and Use in Texas
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/02/2009	Explanation for Other Group Market Type:
	State Status Changed: 10/02/2009
Deemer Date:	Created By: Banu Loyd
Submitted By: Banu Loyd	Corresponding Filing Tracking Number:

Filing Description:

Please see our Cover Letter in the Supporting Documentation tab.

Company and Contact

Filing Contact Information

Banu Loyd, Contract and Compliance Analyst	banu.loyd@nhic.com
P.O. Box 619999	817-640-1900 [Phone] 3748 [Ext]

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Dallas, TX 75261-6199 817-640-3465 [FAX]

Filing Company Information

National Health Insurance Company	CoCode: 82538	State of Domicile: Texas
P.O. Box 619999	Group Code: 4669	Company Type: LAH
Dallas, TX 75261-6199	Group Name: Southwest Ins Partners	State ID Number:
(817) 640-1900 ext. 3410[Phone]	FEIN Number: 74-1541799	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	Same filing fee as home state of Texas.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Health Insurance Company	$100.00	08/27/2009	30164038

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/02/2009	10/02/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	10/01/2009	10/01/2009	Eva Green	10/01/2009	10/01/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Cover Letter HSMPPO-2009P	Banu Loyd	09/30/2009	09/30/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Your Note to Reviewer	Note To Filer	Rosalind Minor	09/30/2009	09/30/2009
Response to Associations Questions	Note To Reviewer	Eva Green	09/29/2009	09/29/2009
Associations	Note To Filer	Rosalind Minor	09/21/2009	09/21/2009

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/02/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document *(revised)*	Cover Letter HSMPPO-2009P	Approved-Closed	Yes
Supporting Document	Cover Letter HSMPPO-2009P	Replaced	Yes
Supporting Document	Copy of Original Cover Letter USA+2002P	Approved-Closed	Yes
Form *(revised)*	Group Hospital Surgical Medical PPO Policy	Approved-Closed	Yes
Form	Group Hospital Surgical Medical PPO Policy	Replaced	Yes
Form *(revised)*	Group Hospital Surgical Medical PPO Certificate	Approved-Closed	Yes
Form	Group Hospital Surgical Medical PPO Certificate	Replaced	Yes
Form	Outpatient Physician Visit Benefit Rider	Approved-Closed	Yes
Form	Individual Application	Approved-Closed	Yes
Form	Supplement to Application	Approved-Closed	Yes

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/01/2009
Submitted Date	10/01/2009
Respond By Date	

Dear Banu Loyd,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Hospital Surgical Medical PPO Policy, HSMPPO-2009P (Form)
- Group Hospital Surgical Medical PPO Certificate, HSMPPO-2009 (Form)

Comment:

On Page 33, please change the phone number for our Department to read: (800)852-5494 and the e-mail address to read: insurance.Consumers@arkansas.gov.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/01/2009
Submitted Date	10/01/2009

Dear Rosalind Minor,

Comments:
Thank you very much for your review of our filing.

Response 1

Comments: We have made the requested changes to page 33 in both the group policy and certificate forms.

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Related Objection 1

Applies To:

- Group Hospital Surgical Medical PPO Policy, HSMPPO-2009P (Form)
- Group Hospital Surgical Medical PPO Certificate, HSMPPO-2009 (Form)

Comment:

On Page 33, please change the phone number for our Department to read: (800)852-5494 and the e-mail address to read: insurance.Consumers@arkansas.gov.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Hospital Surgical Medical PPO Policy	HSMPPO-2009P		Policy/Contract/Fraternal Certificate	Initial		59.200	HSMPPO-2009-GrpPol-AR-100109.pdf
Previous Version							
Group Hospital Surgical Medical PPO Policy	*HSMPPO-2009P*		*Policy/Contract/Fraternal Certificate*	*Initial*		*59.200*	HSMPPO-2009-GrpPol-AR-082609.pdf
Group Hospital Surgical Medical PPO Certificate	HSMPPO-2009		Certificate	Initial		59.200	HSMPPO-2009-Cert-

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

					AR-100109.pdf
Previous Version					
Group Hospital Surgical Medical PPO Certificate	*HSMPPO-2009*	*Certificate*	*Initial*	*59.200*	HSMPPO-2009-Cert-AR-082609.pdf

No Rate/Rule Schedule items changed.

We hope that these revisions will enable you to approve these forms for use in the state of Arkansas. Please let us know if there is anything else we can do to assist in your review. Thank you for your time spent in this matter.

Sincerely,

Eva A. Green, Vice-President/Compliance

Sincerely,
Banu Loyd

We have received your filing regarding the above named association/ discretionary group. To determine if this organization is a qualified group under our statutes, please provide the answers to the following questions:

1. Name and address of the group.
2. Is this group incorporated? If so, give state of incorporation.
3. Is there a current office in Arkansas?
4. Does the Arkansas part of the organization have any officers, committees, or chapters? If so, give details.
5. Are annual dues charged? If so, specify amount.
6. What are the specific activities of the organization?
7. What benefits are provided to the members in addition to insurance? PLEASE ATTACH BROCHURES ON THE BENEFITS.
8. What qualifies an individual for membership?
9. How are members recruited? If by mailing list, advise the source of this list.
10. Attach a copy of the organization by-laws.
11. Also, enclose a list of dues paying members residing in Arkansas with full addresses. If the organization considers this privileged information, we will treat it as such and once it has served our purpose, it will be destroyed.
12. Please attach a copy of the organization's most recent financial statement.
13. Does the organization receive any compensation of any kind from the insurer issuing contracts to its members?

Approval of the organization as a qualified group for insurance purposes will be determined upon receipt of your reply.

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 09/30/2009

Comments:

Dear Ms. Minor:

Thank you very much for your response note today to my questions about the filing of association group information in relation to the submitted forms. We are attaching a revised cover letter which deletes the two association groups which have not been previously approved by the Department. Our intent is that you review the submitted forms for approval for the two association groups listed in the revised letter - United Service Association For Health Care and Small Business Association.

We appreciate your assistance in this matter very much and will look forward to hearing back from you upon completion of the forms review.

Sincerely,

Eva A. Green, Vice-President/Compliance
National Health Insurance Company

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Cover Letter HSMPPO-2009P

Comment: Revised Cover Letter for form filing HSMPPO-2009P with attachment regarding group policyholder information.

CoverLtr2-HSMPPO-2009P-AR.pdf

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Note To Filer

Created By:
Rosalind Minor on 09/30/2009 01:05 PM
Last Edited By:
Rosalind Minor
Submitted On:
10/02/2009 02:13 PM
Subject:
Your Note to Reviewer
Comments:

In your note to reviewer on 9/29/09, you inquired as to whether it would be possible to go ahead and proceed with the filing for the groups that are currently approved. Only if you officially withdraw the request to approve the National Association for Independent Business and the Business Workers of America.

If you officially request withdrawal of these two groups, I could review the forms. When you get the additional information in on the two associations, you could do a separate filing.

I check our approved assoications and American Benefits Association (ABA) has not been approved.

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:
Eva Green on 09/29/2009 05:10 PM
Last Edited By:
Rosalind Minor
Submitted On:
10/02/2009 02:13 PM
Subject:
Response to Associations Questions
Comments:
Dear Ms. Minor --- Thank you very much for your prelimary questions on our filing. We would be glad to gather the requested information for the groups that have not yet been approved by Arkansas. Would it be possible to go ahead and proceed with the submitted filing for the groups that are currently approved in your state?? If so, please advise your preferred method of revising the filing to make this change. Also, would you be kind enough to check your records and let us know if the American Benefits Association (ABA) is approved in Arkansas ??

Thanks very much for your time and consideration --

Eva A. Green, Vice-President/Compliance
National Health Insurance Company
800-237-1900, x3410

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Note To Filer

Created By:
Rosalind Minor on 09/21/2009 02:06 PM
Last Edited By:
Rosalind Minor
Submitted On:
10/02/2009 02:13 PM
Subject:
Associations
Comments:
Before I review the forms for approval, I need additional information on two of the association groups. My records reflect that SBA and USAHC has our Department's approval; therefore, no additional information is needed on these two associations.

On the other two associations, The National Association for Independent Business (NAIB) and Business Workers of american (BWA), please certify that these two associations comply with ACA 23-86-106(2)(A) which states in part that the association has articles of incorporation and bylaws (please attach copy), the association has at least 100 members, and has been organized and maintained in good faith in active existence for at least two (2) years for purposes other than that of obtaining insurance or insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees.

The law further states under ACA 23-86-106(C)(i) that before issuing a group accident and health insurance policy to an association, the association or its insurer on behalf of the association shall filed with the commissioner proof that the association meets the requirement of subdivision (2)(A).

In order for our Department to thoroughly review the association for approval, it is also requested that you provide additional information outlined in the attached questionnaire.

We appreciate your cooperation in this matter.

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/02/2009	HSMPPO-2009P	Policy/Contract/Fraternal Certificate	Group Hospital Surgical Medical PPO Policy	Initial		59.200	HSMPPO-2009-GrpPol-AR-100109.pdf
Approved-Closed 10/02/2009	HSMPPO-2009	Certificate	Group Hospital Surgical Medical PPO Certificate	Initial		59.200	HSMPPO-2009-Cert-AR-100109.pdf
Approved-Closed 10/02/2009	RDR.POV-709	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Outpatient Physician Visit Benefit Rider	Initial		50.220	RDRPOV709.pdf
Approved-Closed 10/02/2009	NH-1175-8/09	Application/Enrollment Form	Individual Application	Revised	Replaced Form #: NH-1175.1/2 Previous Filing #: Previously Approved December 10, 2001		HSMPPO2009_App_809_V.pdf
Approved-Closed 10/02/2009	NH-1161-8/09	Application/Enrollment Form	Supplement to Application	Revised	Replaced Form #: NH-1161-7/1 Previous Filing #: Previously Approved December 10, 2001		Supplemental_App_809.pdf

GROUP HOSPITAL/SURGICAL/MEDICAL INSURANCE POLICY
NATIONAL HEALTH INSURANCE COMPANY

P. O. Box 619999
Dallas, TX 75261-6199
1-800-237-1900

(Referred to in this Policy as the Company, We, Us, Our)

Group Policyholder [ABC Association]

Effective Date [07/01/09]

Group Policy Number [HSMP-ABC]

State of Delivery DC

Premiums due on [1st]

First Renewal Date [08/01/09]

OUR INSURING AGREEMENT: We will pay benefits for certain expenses an Insured incurs, as explained in the Policy, while the Group Policy is in full force as to that person.

We, National Health Insurance Company, issue this Group Policy in consideration of the application and the payment of premiums. Our Company and the Group Policyholder are bound by the conditions and provisions of this Group Policy.

EFFECTIVE DATE: This Group Policy becomes effective at 12:01 A.M. on the Effective Date and in the state specified above. The Group Policy will continue in force by the payment of premiums when due.

ENTIRE POLICY: The following pages, including any riders, endorsements or amendments, along with the application for insurance, constitutes the complete agreement between the Group Policyholder and Us.

Signed at Our Home Office, Grand Prairie, Texas.

Secretary President

GROUP INSURANCE POLICY
NON-PARTICIPATING

INDEX

SCHEDULE A

GROUP POLICYHOLDER: [ABC Association]

POLICY NUMBER: [HSMP-ABC]

AGGREGATE AMOUNT MAXIMUM FOR EACH INJURY OR SICKNESS: [$2,000,000.00]

LIFETIME MAXIMUM: [$10,000,000.00]

NOTICE

Customer Service Department
National Health Insurance Company
Post Office Box 619999
Dallas, Texas 75261-6199
(800)237-1900

Agent's Name, Address, and Telephone Number:

Please see the bottom portion of page 4 of your application which is attached to the policy/certificate for the name of your agent. Call our toll-free number above if you should require the agent's address and/or telephone number.

If we at National Health Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact the Consumer Services Division of the Arkansas Department of Insurance at:

1200 West Third Street
Little Rock, Arkansas 72201-1904
(800) 852-5494 or (501) 371-2640
insurance.consumers@arkansas.gov

PART I - UTILIZATION SERVICES

Our UTILIZATION SERVICES Division provides a comprehensive, coordinated program that seeks to assure the highest quality medical care by combining Utilization Review, Second and Third Surgical Opinions, Pre-admission Testing and Case Management of catastrophic conditions.

FOR ALL UTILIZATION SERVICES, YOU OR YOUR PROVIDER MUST CALL [1-800-237-1900]. Emergency Hospital confinements that occur outside normal business hours must be reported within forty-eight (48) hours or on the first business day after admission.

A. UTILIZATION REVIEW

The goal of Our Utilization Review program is for You to receive necessary and appropriate treatment while avoiding unnecessary expenses when a Hospital confinement or outpatient surgical procedure is being considered. All review services are conducted by professional consultants such as registered nurses and social workers who have access to a panel of Physicians, advisors, and/or a Medical Director.

Utilization Review consists of the Pre-Certification of all non-emergency Hospital admissions or outpatient surgical procedures before services are provided, concurrent stay review, and discharge planning.

Utilization Review is not intended as a substitute for the medical judgment of an attending Physician or any other health care provider. However, if a particular treatment is not Pre-Certified when required, it will not be eligible for maximum benefits.

All Utilization Review decisions may be appealed as described in Part IX of the Group Policy and certificate regarding "Claims Appeal" and Part X regarding "Arbitration of Claim Disputes".

1. PRE-CERTIFICATION

   Pre-Certification does not guarantee that benefits will be paid. Payment of benefits will be determined by the Company in accordance with and subject to all of the terms, provisions, limitations, and exclusions of Your coverage under the Group Policy.

   Before You enter a Hospital on a non-emergency basis or schedule an outpatient surgical procedure, Our Utilization Services Division will, in conjunction with Your Physician, review the proposed treatment for medical necessity and appropriateness. A non-emergency Hospital confinement is one which can be scheduled in advance without endangering the health of the patient.

   The Pre-Certification process is set in motion by a telephone call from either You or Your provider to Our Utilization Services Division at the number specified within the second paragraph of this Part I section of the Group Policy and certificate. The following information is required:

   a. name, social security number, and address of the primary Insured;

   b. name of the Insured patient and relationship to the primary Insured;

   c. certificate or ID number;

   d. name and telephone number of the attending Physician;

e. name and address of the Hospital and the proposed date of admission; and

f. diagnosis and/or type of procedure (including outpatient surgery).

If a condition requires an emergency admission to a Hospital, You (or Your representative), the Hospital or the attending Physician must contact Our Utilization Services Division within forty-eight (48) hours or on the first business day after admission.

If the required Pre-Certification procedures are not followed, ELIGIBLE EXPENSES FOR ALL PROVIDERS WILL BE REDUCED BY THIRTY PERCENT (30%). For each Hospital confinement, Our personnel will determine the number of days of confinement which will be authorized for payment. If charges are incurred for days of confinement that were not authorized, NO BENEFITS WILL BE PAYABLE FOR THE UNAUTHORIZED DAYS.

Pre-Certification is valid for thirty (30) days after the confinement or surgical procedure is authorized. If the treatment does not occur as planned, You or the provider must contact Us again to renew the Pre-Certification. If this renewal procedure is not followed, ELIGIBLE EXPENSES FOR ALL PROVIDERS WILL BE REDUCED BY THIRTY PERCENT (30%).

Pre-Certification is not required for Hospital admissions for maternity that do not exceed forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean section, excluding the date of delivery. Maternity stays in excess of these maximums must be requested by Your attending Physician. NO BENEFITS WILL BE PAID FOR EXCESS UNAUTHORIZED DAYS.

2. CONCURRENT STAY REVIEW AND DISCHARGE PLANNING

Our Utilization Services Division will monitor Your Hospital stay and coordinate with Your attending Physician, and the Hospital, either Your scheduled release from the Hospital or an extension of the Hospital admission. If Your attending Physician feels it is Medically Necessary for You to remain in the Hospital for a greater length of time than originally authorized, the attending Physician must request the additional days prior to the end of the Pre-Authorized confinement. NO BENEFITS WILL BE PAYABLE FOR UNAUTHORIZED DAYS.

B. SECOND AND THIRD SURGICAL OPINIONS

Some surgical procedures are performed unnecessarily or inappropriately. In many instances, surgery is only one of several treatment options. In other situations, surgery will not be of any benefit to the patient. In some cases, surgery can be performed on an outpatient basis.

As medical practices change, specific surgical procedures requiring an additional opinion will also change. Our Utilization Services Division will determine whether a second surgical opinion will be required. For those procedures requiring additional opinions, the additional consultations must be with Physicians who are board certified specialists in the area involved and must not have any financial association with the surgeon recommending the surgery.

If a second surgical opinion does not confirm the need for surgery, then a third opinion will be required. If the third opinion does not confirm the necessity for surgery, all Eligible Expenses will be paid if You desire the procedure, subject to all other terms of the coverage provided under the Group Policy. Second and third consultations will be considered as Eligible Expenses and will not be subject to the Calendar Year Deductible or Co-Insurance requirements.

FAILURE TO OBTAIN REQUIRED ADDITIONAL OPINIONS WILL RESULT IN A THIRTY PERCENT (30%) REDUCTION IN THE ELIGIBLE EXPENSES FOR THE SURGICAL PROCEDURE.

C. ROUTINE PRE-ADMISSION TESTING

Benefits will be payable for a covered Injury or Sickness for routine pre-admission laboratory tests and x-ray examinations when performed on an outpatient basis within seven (7) days prior to a Hospital admission, subject to satisfaction of the Calendar Year Deductible and Co-Insurance requirements. The procedures must be required by the condition causing the Hospital confinement and must be performed in place of the same tests and examinations that would otherwise be conducted during the Hospital confinement. Charges incurred will be considered as Eligible Expenses even if the results reveal that the condition requires medical treatment prior to Hospital admission or that the Hospital admission is not required.

D. CASE MANAGEMENT OF CATASTROPHIC CONDITIONS

When a catastrophic Sickness or Injury requires long term care, after being stabilized in a Hospital, You can possibly be discharged from the Hospital into a more cost effective care setting while still maintaining a high quality level of care. The Case Management program is designed for those situations which involve a large cash outlay for expenses that ordinarily would not be covered under the Group Policy.

Case Management is utilized only when:

1. the catastrophic Sickness or Injury occurs while both You and Your Sickness or Injury are covered under the Group Policy;

2. You have been hospitalized and Your attending Physician determines that the condition is stabilized;

3. You continue to require that Your care be managed but You need not be hospitalized to receive the care;

4. Your placement in a new care setting is contemplated, entailing costs which are not ordinarily reimbursable under the Group Policy; and

5. the Company, the Case Manager, Your attending Physician, and Your legal representative agree to the alternate treatment plan.

The Case Manager will coordinate and implement Your Case Management program and will provide information on resources and suggestions for proper treatment plans. Once an agreement has been reached, the Group Policy will reimburse for all expenses incurred, even if those expenses would normally not be considered as Eligible Expenses, subject to the Aggregate Amount Maximum and the Lifetime Maximum amount.

Case Management is a voluntary service with no reduction of benefits or other penalties attached if You choose not to participate.

PART II - BENEFIT LEVELS

The Company accesses Preferred Provider Networks consisting of Hospitals, Physicians, and other specialty types of health care providers and facilities in which the participating providers (hereafter called "Network Providers") have agreed to provide services at a discounted rate to the Company's Insureds. Benefits will be based on Your choice of a health care provider. You will

choose whether to use a Network Provider at the time that services are needed. There is no requirement to commit in advance to utilizing a Network Provider.

A Network Provider Directory will be made available to You which will list all Network Providers in Your general geographic area. The Company will periodically update this information, but since Network Providers can change, You should call [1-800-237-1900] or visit our website at [www.nhic.com] to make sure that the provider is still a Network Provider before You receive medical services.

The following provisions apply to all benefits provided by the Group Policy with the exception of the Enhanced Outpatient Medical Benefit.

A. CALENDAR YEAR DEDUCTIBLES

IN-NETWORK: The In-Network Calendar Year Deductible amount is shown in Schedule A of the certificate. You can meet this Deductible by incurring Eligible Expenses for services received from either Network or Non-Network Providers.

After three (3) individual In-Network Calendar Year Deductibles have been satisfied by any three (3) Insureds within a family, additional In-Network Calendar Year Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

OUT-OF-NETWORK: The Out-of-Network Calendar Year Deductible amount is shown in Schedule A of the certificate. You can meet this Deductible by incurring Eligible Expenses only from Non-Network Providers.

After three (3) individual Out-of-Network Calendar Year Deductibles have been satisfied by any three (3) Insureds within a family, additional Out-of-Network Calendar Year Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

B. BENEFIT AND CO-INSURANCE PERCENTAGES

After satisfaction of the Calendar Year Deductible requirement(s), Eligible Expenses will be paid at the Benefit Percentage shown in Schedule A of the certificate for either In-Network or Out-of-Network services, based on Your choice of provider. You will be responsible for the Co-Insurance percentage shown in Schedule A of the certificate for either In-Network or Out-of-Network services, based on Your choice of provider.

C. CO-INSURANCE MAXIMUMS

The Co-Insurance Maximum amounts are shown in Schedule A of the certificate. There is an In-Network Co-Insurance Maximum amount and an Out-of-Network Co-Insurance Maximum amount. You can meet both these amounts simultaneously with Eligible Expenses incurred for services received from either a Network or a Non-Network Provider, up to the amount of the In-Network Co-Insurance Maximum. After the In-Network Co-Insurance Maximum amount has been satisfied, only Eligible Expenses incurred for services received from a Non-Network Provider can be used to satisfy any remaining Out-of-Network Co-Insurance Maximum amount.

After You meet the In-Network Deductible and In-Network Co-Insurance Maximum amount, additional Eligible Expenses incurred during that same Calendar Year, for services received from a Network Provider, will not be subject to Co-Insurance.

After You meet the Out-of-Network Deductible and Out-of-Network Co-Insurance Maximum amount, additional Eligible Expenses incurred during that same Calendar Year, for services received from a Non-Network Provider, will not be subject to Co-Insurance.

Co-Insurance Maximum amounts apply to each Insured each Calendar Year even though a condition or claim may continue from one (1) Calendar Year to the next. After three (3) Insureds within a family have met the In-Network Co-Insurance Maximum amount in a Calendar Year, additional Eligible Expenses of any Insured within the same family will not be subject to Co-Insurance for the remainder of that same Calendar Year.

This provision applies to all benefits where there is a differential between the amounts payable for services received from Network versus Non-Network Providers:

D. MEDICAL EMERGENCY SERVICES

If You cannot reasonably access a Network Provider, the following emergency care services will be reimbursed at the Network Provider level of benefits until You can reasonably be expected to transfer to a Network Provider:

1. a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital that is necessary to determine whether a Medical Emergency condition exists;

2. necessary emergency care services, including the treatment and stabilization of a Medical Emergency condition; and

3. services originating in a Hospital emergency facility following treatment or stabilization of a Medical Emergency condition.

PART III - ELIGIBLE EXPENSES

Subject to the provisions set forth in this section and all other terms of the Group Policy, charges for the services described in the following paragraphs will qualify as Eligible Expenses and will be considered for payment. All benefits payable are subject to the Aggregate Amount Maximum of [two million dollars ($2,000,000.00)] per Injury or Sickness and a Lifetime Maximum amount of [ten million dollars ($10,000,000.00)] for all combined claim payments for all Insureds.

Eligible Expenses must meet the following requirements in order to be considered for payment:

1. any Injury is sustained or first occurs on or after the Effective Date of Your coverage under the Group Policy and while Your coverage is in force;

2. any Sickness first Manifests itself after the Effective Date of Your coverage under the Group Policy and while Your coverage is in force;

3. the Eligible Expense is incurred while Your coverage under the Group Policy is in force; and

4. any loss for any Pre-Existing Condition, which is not excluded by endorsement or by name or specific description, occurs after You have been covered for twenty-four (24) months under the Group Policy.

A. INPATIENT HOSPITAL EXPENSES

If You receive treatment in a Hospital on an inpatient basis for a covered Injury or Sickness, Eligible Expenses under this benefit will be the Usual and Customary Charges for Hospital expenses incurred in the course of Your treatment, excluding:

1. ambulance charges (covered under separate benefit paragraph);

2. charges for Hospital room and board in excess of the Hospital's most prevalent semi-private room rate (except for Intensive Care Unit charges);

3. charges for personal, comfort, or convenience items such as telephone, television, or radio;

4. take home items, including but not limited to drugs and medicines;

5. charges for any other items or services which are not Medically Necessary; and

6. charges for any days of confinement not authorized in the Pre-Certification or Concurrent Stay Review process.

B. INPATIENT MEDICAL EXPENSES

If You receive treatment in a Hospital on an inpatient basis for a covered Injury or Sickness, Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for the items of medical expense listed herein. The eligible items of expense are:

1. Surgeons' fees for surgical operations;

2. Assistant Surgeons' fees for surgical operations;

3. Anesthesiologists' fees;

4. Physicians' Visits at Hospital (not payable to surgeon or assistant surgeon);

5. Pathologists' fees;

6. Radiologists' fees; and

7. Physiotherapists' fees.

C. OUTPATIENT SURGICAL EXPENSES

If You have a surgical operation that is performed on an outpatient basis in a Physician's office or clinic, Hospital, or ambulatory surgery facility due to a covered Injury or Sickness, the Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for the items of expense listed herein. The eligible items of expense are:

1. Hospital or ambulatory surgery facility fees;

2. Surgeons' fees for surgical operations;

3. Assistant Surgeons' fees for surgical operations;

4. Anesthesiologists' fees;

5. Pathologists' fees; and

6. Radiologists' fees.

D. WELL CHILD CARE

If You incur expenses for preventive and primary care services provided by a Physician or under the supervision of a Physician during unlimited visits for Eligible Dependent children up to the

age of twelve (12) and during three (3) visits per Calendar Year for children ages twelve (12) to twenty-one (21), Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for such services. Preventive and primary care services shall include physical examinations, measurements, sensory screening, neuropsychiatric evaluation, developmental screening and anticipatory guidance. Eligible Expenses will also include hereditary and metabolic screening at birth, urinalysis, tuberculin tests and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy, hypothyroidism, phenylketonuria (PKU), galactosemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas. The Usual and Customary Charges for immunization services, without application of the Calendar Year Deductible or Co-Insurance, will also be considered as Eligible Expenses under this benefit.

In addition, Eligible Expenses under this benefit include the Usual and Customary Charges incurred for routine Hospital nursery care and pediatric charges for a child born to the Insured named in Schedule A of the certificate on or after the Effective Date of the certificate. Benefits will be payable for up to five (5) full days in a Hospital nursery or until the parent is discharged from the Hospital following the birth of the child, whichever is the lesser period of time. Eligible Expenses for the child will be subject to the Calendar Year Deductible and Co-Insurance for the child.

E. DIABETES SERVICES

If You have been diagnosed with insulin-dependent, insulin-using, gestational, or non-insulin using diabetes or elevated blood glucose levels resulting from another medical condition, Eligible Expenses under this benefit will be the Usual and Customary Charges for Medically Necessary equipment, supplies, and services which are provided or prescribed by a Physician in the course of Your treatment.

Eligible Expenses will also include the Usual and Customary Charges for outpatient self-management training and education, including medical nutritional therapy when prescribed by Your Physician.

F. HOME HEALTH CARE

If You incur expenses for Home Health Care, such expenses will qualify as Eligible Expenses if:

1. expenses are incurred beginning within fourteen (14) days after being discharged from a Hospital where treatment was received for a covered Injury or Sickness;

2. Your Physician certifies that without Home Health Care, You would have to remain Hospital confined to receive proper treatment;

3. You continue to need care and treatment in Your place of residence; and

4. Your Physician submits a Home Health Care plan in writing to the Company.

Eligible Expenses under this benefit will be the Usual and Customary Charges for Home Health Care for the following services, to a maximum of [twenty thousand dollars ($20,000.00)] per Calendar Year per Insured.

Skilled Nursing Care
Physical Therapy
Occupational Therapy
Medical/Social Work
Nutritional Services
Respiratory Therapy
Speech Therapy
Medical Appliances and Equipment
Prescription Drugs
Laboratory Services
Home Health Aid Visits

Home Health Care does not include and no benefits will be payable for custodial care or services or supplies not included in the Home Health Care plan submitted by Your Physician.

The Company's Case Management Services will be available to You and Your family. There is no reduction of benefits or other penalties attached if You choose not to utilize these services.

G. HOSPICE CARE

If You should require Hospice Care for a covered Injury or Sickness, Eligible Expenses under this benefit will be the Usual and Customary Charges for Hospice Care to a lifetime maximum per Insured of the lesser of one hundred eighty (180) days or [ten thousand dollars ($10,000.00)], if:

1. Your Physician certifies that Your life expectancy is less than six (6) months;

2. Your Physician recommends a Hospice Care program for Your benefit and that of Your immediate family;

3. the services and supplies are ordered by a Physician who directs the Hospice Care program; and

4. the services and supplies are provided to reduce or abate pain or other symptoms of distress and to meet the stresses of dying.

The Company's Case Management Services will be available to You and Your family. There is no reduction of benefits or other penalties attached if You choose not to utilize these services.

H. AMBULANCE

If You require transportation by ambulance for treatment of a covered Injury or Sickness, Eligible Expenses under this benefit will be such ambulance transportation expenses to a maximum of [five hundred dollars ($500.00)] per Insured per Calendar Year.

I. WOMEN'S HEALTH AND CANCER RIGHTS

The United States Congress passed legislation effective October 21, 1998 which requires individual and group health plans to provide reconstructive surgery benefits if the plan normally provides medical and surgical benefits for a mastectomy. The required coverage consists of:

1. reconstruction of the breast on which the mastectomy was performed; and

2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. prostheses and physical complications from all stages of a mastectomy including lymphedemas.

These benefits must be provided in a manner determined in consultation with the attending provider and the patient. The coverage will be subject to the same Deductible, Co-Insurance, and other benefit provisions as for similar types of expenses covered under the plan for other Sicknesses. These benefits will not duplicate any other benefits payable under the plan. Coverage provided will be in accordance with federal and state law and applicable regulations.

J. ENHANCED OUTPATIENT MEDICAL BENEFIT

This paragraph is NOT SUBJECT to the Calendar Year Deductibles, Benefit Percentages, Co-Insurance Percentages, or Co-Insurance Maximums shown in Schedule A of the certificate. Separate Deductible amounts, benefit percentages, and co-insurance maximum apply to this paragraph. Eligible Expenses incurred under this benefit may not be used to

satisfy the Calendar Year Deductibles or Co-Insurance Maximums shown in Schedule A of the certificate.

The Enhanced Outpatient Medical Benefit Deductible amounts are shown in Schedule A of the certificate and apply to each Insured each Calendar Year. There is an In-Network Deductible amount and an Out-of-Network Deductible amount. These Deductible amounts may be satisfied only with Eligible Expenses incurred under the Enhanced Outpatient Medical Benefit.

You can meet the In-Network Enhanced Outpatient Medical Benefit Deductible amount by incurring Eligible Expenses for services received from either Network or Non-Network Providers. After three (3) total In-Network Deductibles have been satisfied by any three (3) Insureds within a family, additional In-Network Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

You can meet the Out-of-Network Enhanced Outpatient Medical Benefit Deductible amount by incurring Eligible Expenses only from Non-Network Providers. After three (3) total Out-of-Network Deductibles have been satisfied by any three (3) Insureds within a family, additional Out-of-Network Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

Eligible Expenses are the Usual and Customary Charges incurred for THE FOLLOWING outpatient services/treatments which You receive in a Physician's office or clinic, Hospital, or ambulatory surgery facility due to a covered Injury or Sickness. After the Deductible requirement(s) have been met from Eligible Expenses, benefits will be paid at [eighty percent (80%)] of Usual and Customary Charges for services received from a Network Provider or [sixty percent (60%)] of Usual and Customary Charges for services received from a Non-Network Provider for the next [ten thousand dollars ($10,000)] of Eligible Expenses. Thereafter, during that same Calendar Year, Eligible Expenses will be paid at [one hundred percent (100%)] of Usual and Customary Charges. You are responsible for the Deductible requirement(s), Your portion of Eligible Expenses incurred after the Deductible is satisfied, and any non-covered charges. These benefit payment provisions apply to the expenses incurred for each Insured individually.

Pathology (Lab. Services)
Radiology (X-Rays)
Upper/Lower G.I. Series
CAT Scans
Magnetic Resonance Imaging
Nerve Conduction Studies
Emergency Room Facility Fees
Non-Surgical Anesthesia
Casts, Splints & Braces
Surgical Dressings
Central Supplies
Kidney Dialysis
Chemotherapy Treatments
Cobalt Treatments
Irradiation Treatments
Ultrasound
Sonograms
Myelograms
Pyelograms
Angiograms
Electrocardiograms
Electroencephalograms
Electromyograms
Pneumoencephalograms
Durable Medical Equipment - Maximum of $2,500 per Insured per Calendar Year.
Physical Therapy - Not to exceed the lesser of 25 treatments or $2,000 per Insured per Calendar Year.
Occupational Therapy - Not to exceed the lesser of 25 treatments or $2,000 per Insured per Calendar Year.

Total benefits provided will be **LIMITED TO THOSE SERVICES LISTED ABOVE** and shall not exceed [two hundred fifty thousand dollars ($250,000.00)] of Eligible Expenses per Insured per Calendar Year. Kidney dialysis must be received in a Medicare approved dialysis center. This benefit does not provide coverage for Physician fees (including but not limited to Physician fees for office or clinic visits, routine physical exams, or surgery), prescription drugs or any other service not specifically listed.

K. MAMMOGRAPHY AND CYTOLOGIC SCREENING

This benefit is NOT SUBJECT to satisfaction of the Calendar Year Deductibles or Co-Insurance.

If You receive any of the following services, Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for such services. The eligible services are:

1. an annual cervical cytologic screening for a female Insured;

2. any cervical cytologic screening for a female Insured which her Physician certifies to be Medically Necessary;

3. a baseline mammogram and annual mammograms thereafter for a female Insured; and

4. any mammogram for a female Insured which is certified to be Medically Necessary by her Physician or which is recommended by her Physician where such Insured or her mother or sister has had a history of breast cancer.

Eligible Expenses for cervical cytologic screening include only the laboratory charges for the test and do not include the Physician office visit charge.

L. PROSTATE CANCER SCREENING

This benefit is NOT SUBJECT to satisfaction of the Calendar Year Deductibles.

Eligible Expenses under this benefit will be the Usual and Customary Charge for prostate cancer screening performed by a Physician in accordance with the National Comprehensive Cancer Network guidelines in effect as of January 1, 2009 for the ages, family histories, and frequencies referenced in such guidelines. If a Physician recommends that You undergo a prostate specific antigen blood test, We may not deny coverage for the test on the basis of a previous negative digital rectal examination.

M. TREATMENT OF CATASTROPHIC METABOLIC DISORDERS

If You have been diagnosed with a Catastrophic Metabolic Disorder, Eligible Expenses under this benefit will be charges incurred for Medically Necessary amino acid modified preparations, Medical Foods, Low Protein Modified Food Products and any other special dietary products and formulas prescribed and administered by a Physician for the therapeutic treatment of Catastrophic Metabolic Disorders which are in excess of two thousand four hundred dollars ($2,400.00) in a Calendar Year.

"Catastrophic Metabolic Disorder" means phenylketonuria (PKU), galactosemia, organic acidemias, and disorders of amino acid metabolism.

"Inherited Metabolic Disease" means a disease caused by an inherited abnormality of body chemistry.

"Low Protein Modified Food Product" means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease.

"Medical Food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

N. MUSCULOSKELETAL DISORDERS OF THE FACE, NECK OR HEAD

Eligible Expenses under this benefit are the Usual and Customary Charges incurred for surgical or nonsurgical medical treatment of a musculoskeletal disorder affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder. Coverage will be provided for Medically Necessary diagnosis and treatment of these conditions regardless of cause and whether prescribed or administered by a dentist or a Physician. Benefits will be payable only to the same extent as for any other Sickness covered under the Group Policy.

O. COLORECTAL CANCER SCREENING

Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for Colorectal Cancer Screening for Insureds who are:

1. fifty (50) years of age or older;

2. less than fifty (50) years of age but who are at High Risk for Colorectal Cancer; or

3. Symptomatic of Colorectal Cancer as determined by a Physician.

Benefits for Colorectal Cancer Screening services will include an examination of the entire colon including the following examinations and laboratory tests:

1. an annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;

2. a double-contrast barium enema every five (5) years; or

3. a colonoscopy every ten (10) years.

The Insured will determine the choice of screening strategies in consultation with a Physician. Benefits will also include any additional medically recognized screening tests for colorectal cancer required by the Director of the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations.

This benefit will also include coverage for follow-up screenings based on the following guidelines:

1. if an initial colonoscopy was normal, a follow-up screening after ten (10) years;

2. if the Insured had one (1) or more neoplastic polyps or adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, a follow-up screening after three (3) years;

3. if the Insured had a single tubular adenoma of less than one centimeter (1 cm), a follow-up screening after five (5) years; or

4. if the Insured had large sessile adenomas greater than three centimeters (3 cm), especially if removed in a piecemeal fashion, a follow-up screening in six (6) months or until complete polyp removal is verified by colonoscopy.

"High Risk for Colorectal Cancer" means:

1. the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy;

2. a family history of colorectal cancer in close relatives such as parents, brothers, sisters, or children;

3. genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis;

4. a personal history of colorectal cancer, ulcerative colitis, or Crohn's disease;

5. the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; or

6. any additional or expanded definition of "High Risk for Colon Cancer" as recognized by medical science and determined by the Director of the Division of Health of the Department of Health and Human Services in consultation with the University of Arkansas for Medical Sciences.

"Symptomatic of Colorectal Cancer" includes:

1. bleeding from the rectum or blood in the stool; or

2. a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

P. SPEECH OR HEARING IMPAIRMENT

Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for the necessary care and treatment of loss or impairment of speech or hearing. "Loss or Impairment of Speech or Hearing" shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of the provider's area of certification.

This benefit will include coverage for a hearing aid purchased from a professional licensed in the state of Arkansas to dispense a hearing aid. The maximum benefit amount payable for a hearing aid is one thousand four hundred dollars ($1,400.00) per ear in a three year period and is not subject to Deductible or Co-Insurance requirements.

"Hearing aid" means an instrument or device, including repair and replacement parts, that:

1. is designed and offered for the purpose of aiding persons with or compensating for impaired hearing;

2. is worn in or on the body; and

3. is generally not useful to a person in the absence of a hearing impairment.

Q. ORTHOTIC DEVICES/SERVICES AND PROSTHETIC DEVICES/SERVICES

Eligible Expenses under this benefit will be eighty percent (80%) of Medicare allowable charges as defined by the Center for Medicare and Medicaid Services Healthcare Common Procedure Coding System as of January 1, 2009 or as later revised, for the following Medically Necessary items prescribed and provided by a Physician:

1. an Orthotic Device;

2. an Orthotic Service;

3. a Prosthetic Device; and

4. a Prosthetic Service.

This benefit will include Medically Necessary replacement once every three (3) years unless more frequent replacement is Medically Necessary. Coverage will include replacement or repair necessitated by anatomical change or normal use of an Orthotic or Prosthetic Device unless the repair or replacement is due to misuse or loss. If We deny or limit coverage under this benefit based on lack of Medical Necessity, External Review is available to You as described in Part IX.H. of the Group Policy and certificate.

"Orthotic Device" means an external device that is intended to restore physiological function or cosmesis to a patient and is custom made, fitted, or adjusted for the patient. Orthotic Device does not include a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that is carried in stock by the seller and sold without therapeutic modification and has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

"Orthotic Service" means the evaluation and treatment of a condition that requires the use of an Orthotic Device.

"Prosthetic Device" means an external device that is intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and that is custom made, fitted, or adjusted for the patient. Prosthetic Device does not include an artificial eye, a dental appliance, a cosmetic device such as eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

"Prosthetic Service" means the evaluation and treatment of a condition that requires the use of a Prosthetic Device.

PART IV - EXCLUSIONS AND LIMITATIONS

No payment will be made for claims resulting in or from:

1. a Pre-Existing Condition, which is not excluded by endorsement or by name or specific description, unless the expense is incurred after You have been covered for more than twenty-four (24) months under the Group Policy, excluding newborns and adoptees as provided in Part VI of the Group Policy and certificate;

2. any Injury that was sustained prior to Your Effective Date of coverage under the Group Policy;

3. normal childbirth;

4. prenatal care;

5. Mental or Emotional Disorders, unless specifically provided in the Group Policy due to state mandates and described in the certificate;

6. treatment for alcohol or chemical substance use, abuse, or dependency or illegal drug use or experimentation, unless specifically provided in the Group Policy due to state mandates and described in the certificate;

7. any loss incurred where a contributing factor to the loss was You being Intoxicated or under the influence of any substance which has the capacity to disturb Your mental, emotional, or physical faculties, unless administered on the advice of a Physician;

8. any expenses which exceed the Usual and Customary Charges;

9. any expenses incurred which are not Medically Necessary;

10. aviation (while acting as a pilot or crew member);

11. war or act of war (declared or undeclared);

12. participation in a felony, riot or insurrection;

13. service in the armed forces or units auxiliary thereto (upon notice of Your entry into the armed forces or units auxiliary thereto, You will receive a partial refund of unearned premiums, if any);

14. suicide or intentionally self-inflicted harm;

15. cosmetic surgery, except that surgery resulting from a covered Injury or covered Sickness and reconstructive surgery because of congenital disease or anomaly which has resulted in a functional defect of an Eligible Dependent child born to or placed for adoption with the Insured named in Schedule A of the certificate on or after its Effective Date;

16. breast reduction or augmentation even if Medically Necessary, unless due to reconstructive surgery which is needed as a result of a mastectomy performed due to a diagnosis of breast cancer;

17. dental care or treatment, except that dental treatment caused by an Accidental Injury;

18. weight loss procedures even if Medically Necessary;

19. voluntary abortions, sterilization procedures, or reversals of sterilization procedures;

20. penile implants even if Medically Necessary;

21. sex transformation procedures, hormones for such treatment and charges for related psychiatric care or counseling;

22. infertility treatment including but not limited to artificial insemination, in vitro fertilization, or embryo transfer procedures;

23. experimental treatment or experimental surgery not recognized by the American Medical Association, or considered to be experimental or investigational by any appropriate health care technological assessment body established by a state or federal government;

24. Radial Keratotomy or similar procedures to improve vision, eyeglasses, contact lenses, and examination for the prescription or fitting thereof;

25. any loss covered by worker's compensation, employer's liability benefits, or occupational disease law;

26. services performed by a member of Your family, services for which no charge is normally made in the absence of insurance, or services of a federal, veterans', state or municipal Hospital (unless You are financially responsible for the charges);

27. any expenses paid for under another part of the Group Policy;

28. legal expenses, whether or not incurred to obtain medical treatment;

29. any expense for which Medicare benefits are payable (benefits will not be reduced or denied because the medical expense was covered by the Medical Assistance Act of 1967, better known as Medicaid);

30. routine physical examinations for adult Insureds unless specifically provided in the Group Policy due to state mandates and described in the certificate; and

31. any item not specifically listed in the Group Policy and certificate as a benefit.

PART V - DEFINITIONS

A. "ACCIDENT/ACCIDENTAL" means any sudden or unforeseen event which results in accidental bodily Injury sustained by an Insured which is the direct cause, independent of disease or bodily infirmity or any other cause, and occurs while the Insured's coverage under the Group Policy is in force.

B. "AGGREGATE AMOUNT MAXIMUM" means the maximum amount of Eligible Expenses that will be covered under the Group Policy for each Injury or Sickness with respect to each Insured. The Aggregate Amount Maximum is shown in Schedule A.

C. "ASSOCIATION" means the Group Policyholder as shown in Schedule A.

D. "CALENDAR YEAR" means the period beginning January 1 of any year and ending December 31 of the same year.

E. "CO-INSURANCE" means the percentage of Eligible Expenses that are to be paid by You based on Your choice of Provider, after satisfaction of the Calendar Year Deductible requirements. The Co-Insurance Percentages are shown in Schedule A of the certificate unless specified otherwise in the benefit description.

F. "CO-INSURANCE MAXIMUM" means the total amount of Eligible Expenses that each Insured is required to incur each Calendar Year, after satisfaction of the Calendar Year Deductible requirements, before the Group Policy will pay one hundred percent (100%) of all additional Eligible Expenses incurred for that Insured during that Calendar Year.

The Co-Insurance Maximum amounts are shown in Schedule A of the certificate. There is an In-Network Co-Insurance Maximum amount and an Out-of-Network Co-Insurance Maximum amount. Eligible Expenses which are not subject to payment of Co-Insurance cannot be used to satisfy the Co-Insurance Maximums.

Co-Insurance Maximum amounts apply to each Insured each Calendar Year even though a condition or claim may continue from one (1) Calendar Year to the next. After three (3) Insureds within a family have met the In-Network Co-Insurance Maximum amount in a Calendar Year, additional Eligible Expenses of any Insured within the same family will not be subject to Co-Insurance for the remainder of that same Calendar Year.

G. "COMPLICATIONS OF PREGNANCY" means:

1. Hospital confinement required to treat conditions, such as the following, in a pregnant female: acute nephritis; nephrosis; cardiac decompensation; HELLP syndrome; uterine rupture; amniotic fluid embolism; chorioamnionitis; fatty liver in pregnancy; septic abortion; placenta accreta; gestational hypertension; puerperal sepsis; peripartum cardiomyopathy; cholestasis in pregnancy; thrombocytopenia in pregnancy; placenta previa; placental abruption; acute cholecystitis and pancreatitis in pregnancy; postpartum hemorrhage; septic pelvic thromboplebitis; retained placenta; venous air embolus associated with pregnancy; miscarriage; or an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of

descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section.

2. Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism; hepatitis B or C; HIV; Human papilloma virus; abnormal PAP; syphilis; Chlamydia; herpes; urinary tract infections; thromboembolism; appendicitis; hypothyroidism; pulmonary embolism; sickle cell disease; tuberculosis; migraine headaches; depression; acute myocarditis; asthma; maternal cytomegalovirus; urolithiasis; DVT prophylaxis; ovarian dermoid tumors; biliary atresia and/or cirrhosis; first trimester adnexal mass; hyditidiform mole; or ectopic pregnancy.

H. "DEDUCTIBLE" means the amount of Eligible Expenses for which no benefits are payable in any one Calendar Year. The Calendar Year Deductibles are based on Your choice of provider and are shown on the Schedule A page of the certificate. The Deductible is Your sole responsibility and must be satisfied by incurring charges which are Eligible Expenses under the terms of the Group Policy, excluding those Eligible Expenses that are not subject to the Calendar Year Deductible. Part II.A. of the Group Policy and the certificate sets forth the Deductible requirements.

If two (2) or more Insureds in the same family are injured in the same Accident, only one (1) Deductible and one (1) Co-Insurance Maximum amount will be required during that Calendar Year for all Eligible Expenses resulting from Injuries sustained in the Accident.

Certain benefits under the Group Policy may not be subject to the Calendar Year Deductibles shown in Schedule A of the certificate. These benefits may instead be subject to a separate Deductible for that particular benefit. These types of provisions are set forth in the description for the particular benefit.

I. "EFFECTIVE DATE" means the date shown in Schedule A of the certificate on which coverage begins for Insureds who were listed on the original application and for whom issuance of coverage was approved. The Effective Date of coverage for an Insured who is added at a later date will be shown on an endorsement which will be issued by the Company to provide evidence of the addition.

J. "ELIGIBLE DEPENDENT(S)" means:

1. the legal spouse of the Insured named in Schedule A of the certificate;

2. an unmarried child of either the Insured named in Schedule A of the certificate or that Insured's legal spouse, who is:

   a. less than nineteen (19) years old;

   b. less than twenty-four (24) years old and in regular full-time attendance at any college or university accredited as an institution of higher learning. "Full-time attendance" shall mean twelve (12) credit hours per semester; or

   c. medically certified as disabled and dependent upon the Insured named in Schedule A of the certificate, regardless of age.

"Spouse" includes a domestic partner or participant in a civil union if the relationship is legally recognized in Your state or jurisdiction of residence.

"Child" includes a natural child, a legally adopted child, or a child placed for adoption with the Insured named in Schedule A of the certificate on or after its Effective Date. "Child" also includes a minor grandchild, niece, or nephew who is under the primary care of the Insured named in Schedule A of the certificate, if the legal guardian of the child other than the Insured named in Schedule A of the certificate is not covered by an accident and sickness plan. "Primary care" means the provision of food, clothing, and shelter on a regular and continuous basis during the time that public school is in regular session.

K. "ELIGIBLE EXPENSES" are those benefits contained in the Group Policy and described in the certificate. Services and materials will be considered Eligible Expenses only to the extent that:

1. expenses do not exceed the Usual and Customary Charges;

2. expenses are incurred while Your coverage is in force under the Group Policy; and

3. services and materials are Medically Necessary and are furnished at the direction of or under the supervision of a Physician.

L. "HOME HEALTH CARE" means care which is provided by a public or private agency that specializes in giving nursing and other therapeutic services in Your home or place of residence. The agency must be licensed as such or, if no license is required, approved by a state department or agency having authority over Home Health Care.

M. "HOSPICE CARE" means treatment provided by a public agency or private organization which meets all of the following requirements:

1. is primarily engaged in providing care to terminally ill patients;

2. provides twenty-four (24) hour care to control the symptoms associated with terminal Sickness;

3. has on its staff an interdisciplinary team which includes at least one (1) Physician, one (1) registered nurse (RN), one (1) social worker, and at least one (1) pastoral or other counselor, and volunteers;

4. is a licensed organization whose standards of care meet those of the National Hospice Organization;

5. maintains central clinical records on all patients;

6. provides appropriate methods of dispensing drugs and medicines; and

7. offers a coordinated program of home care and inpatient care for a terminally ill patient and the patient's family.

The term "Hospice" does not include any organization or part thereof which is primarily engaged in providing custodial care, or care for drug abusers, drug addicts, alcohol abusers, or alcoholics, or domestic services, a place of rest, a place for the aged, or a hotel or similar institution.

N. "HOSPITAL" means only an institution which meets the following requirements:

1. is an institution operated pursuant to law; and

2. is primarily engaged in providing or operating - either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under supervision of a staff of one (1) or more duly licensed Physicians - medical, diagnostic and surgical

facilities for medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

3. provides twenty-four (24) hour nursing service by or under the supervision of registered nurses (RNs).

The term "Hospital" also means ambulatory surgical center, provided that any services performed therein would have been covered under the terms of the Group Policy as an eligible inpatient service.

This definition shall not include an institution, or that part of an institution, operating primarily:

1. as a convalescent home, rest, nursing, or convalescent facility; or

2. as a facility affording custodial or educational care, or a facility for the aged; or

3. as a military Hospital, veterans' Hospital, or soldiers' home or any institution contracted for or operated by the federal government or any agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered where a legal liability exists for charges made to the individual for such services.

O. "INJURY" means bodily harm caused by an Accident, directly and independently of all other causes. The Injury must occur while Your coverage is in force.

P. "INSURED" means the Association member named in Schedule A of the certificate and all covered Eligible Dependents.

Q. "INTOXICATED/INTOXICATION" means a level of blood alcohol content that is specified in the laws defining Intoxication in the state where the loss or cause of loss occurred.

R. "LIFETIME MAXIMUM" means the maximum amount of Eligible Expenses that will be covered under the Group Policy for all claims submitted by the Insured named in Schedule A of the certificate and his or her covered Eligible Dependents, after which coverage for that Insured and his or her Eligible Dependents will become null and void. The Lifetime Maximum is shown in Schedule A.

S. "MANIFESTS/MANIFESTED" means that a condition is active and that there is a distinct symptom (or symptoms) from which a Physician could diagnose the condition with reasonable accuracy or when a symptom (or symptoms) is of sufficient severity to cause a person to seek medical diagnosis or treatment.

T. "MEDICAL EMERGENCY" means the sudden onset or sudden worsening of a medical condition which is evidenced by symptoms of such severity, including severe pain, that a failure to immediately provide medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

1. placing the patient's mental or physical health in serious jeopardy;

2. serious impairment to bodily functions;

3. serious dysfunction of any bodily organ or part;

4. serious disfigurement; or

5. in the case of a pregnant woman, serious jeopardy to the health of a fetus.

U. "MEDICALLY NECESSARY" means a service or supply which is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on current generally accepted medical practice. A service or supply will not be considered as Medically Necessary if:

1. it is provided only as a convenience to You or a health care provider;

2. it is not appropriate treatment for Your diagnosis or symptoms;

3. it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or

4. it is part of a plan of treatment that is experimental, unproven or related to a research protocol, in the sense that its effectiveness is not generally recognized by the medical community.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

V. "MEDICAID" means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

W. "MEDICARE" means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

X. "MENTAL OR EMOTIONAL DISORDER" means a neurosis, psychoneurosis, psychosis, or a mental or emotional disease or disorder of any kind as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

Y. "NETWORK PROVIDER" means any Hospital, Physician or other provider of medical services that has contracted with Preferred Provider Networks to furnish such services at discounted rates to the Company's Insureds. A provider who has terminated his/her contract with the Preferred Provider Network is not a "Network Provider".

Z. "NON-NETWORK PROVIDER" means any Hospital, Physician, or other provider of medical services that does not have a contract to provide services at discounted rates to the Company's Insureds through a Preferred Provider Network.

AA. "PHYSICIAN" means a duly licensed Doctor of Medicine, Osteopath, Podiatrist, Chiropractor, Midwife, Nurse Anesthetist, Psychologist or any other health care practitioner providing a covered service and acting within the scope of his or her license who is required to be recognized by any law applicable to health insurance in the state where the service is provided. The term "Physician" does not include the Insured or an Insured's close relative - spouse, domestic partner, parent, sister, sister-in-law, brother, brother-in-law, aunt, uncle, grandparent, niece, nephew, child or cousin - or an individual residing in an Insured's household.

BB. "PRE-CERTIFICATION/PRE-CERTIFIED" means the process described in Part I of the Group Policy and the certificate whereby Our Utilization Services Division reviews a proposed non-emergency Hospital confinement, outpatient surgical procedure or emergency Hospital confinement for medical necessity and appropriateness.

CC. "PRE-EXISTING CONDITION" means the existence of symptoms which would cause a person to seek diagnosis, care or treatment within the twelve (12) month period preceding the Effective Date of coverage under the Group Policy;

OR

a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within the twelve (12) month period preceding the Effective Date of coverage under the Group Policy.

DD. "SCHEDULE A" means the schedule found on page 3.

EE. "SICKNESS" means an illness or disease which first Manifests itself after the Effective Date of Your coverage under the Group Policy and while such coverage is in force. Sickness includes congenital illnesses or defects in newborn Eligible Dependents or children placed for adoption with the Insured named in Schedule A of the certificate on or after its Effective Date.

Sickness also includes Complications of Pregnancy which occur after Your Effective Date of coverage under the Group Policy. Sickness does not include normal pregnancy.

FF. "TOTALLY DISABLED/TOTAL DISABILITY" means:

1. with respect to the Insured named in Schedule A of the certificate, or a covered spouse or domestic partner, that he or she is unable to perform, by reason of Injury or Sickness, the material and substantial duties of his or her occupation and is under the regular care and attendance of a Physician for the condition causing the Total Disability;

2. with respect to an Eligible Dependent, other than a covered spouse or domestic partner, that he or she is prevented, by reason of Injury or Sickness, from engaging in the normal and customary duties and activities of a person of like age and sex, and is under the regular care and attendance of a Physician for the condition causing the Total Disability.

GG. "USUAL AND CUSTOMARY CHARGES" means:

1. For services provided by Network Providers: the contracted rate in effect for that Network Provider on the date that the service is provided to an Insured; or

2. For services provided by a Non-Network Provider: charges for medical services or supplies which are in an amount not exceeding the normal rates charged for the same or similar services or supplies in the geographic region where the service or supply is furnished. Geographic region is a zip code, city, county, or such area as is necessary to obtain a representative cross section of medical and Hospital costs.

HH. "WE", "US", or "OUR" means the National Health Insurance Company. Also referred to as the "Company".

II. "YOU" and "YOUR" means all Insureds.

PART VI - ELIGIBILITY PROVISIONS

A. ELIGIBILITY AND EFFECTIVE DATE

1. EFFECTIVE DATE

   Persons who apply for this coverage must provide evidence of insurability satisfactory to the Company in order for the Company to issue coverage. The Effective Date is shown in Schedule A of the certificate for all applicants listed on the original application for

insurance. The Effective Date for Eligible Dependents who apply for coverage at a later date will be the first day of the month following the date on which the Company approves the Eligible Dependent's insurability, except for newborns and adoptees as provided in the following paragraphs.

2. NEWBORN CHILDREN

   If a child is born to the Insured named in Schedule A of the certificate on or after the Effective Date of the certificate, the child will be immediately covered under the Group Policy as of the moment of birth. This automatic coverage will cease at the end of ninety (90) days. To continue coverage beyond the ninety (90) day period, You must notify Us in writing at the address shown on page 1 of the certificate prior to the end of the automatic coverage, of Your desire to add the child permanently to Your coverage. Any premium due for the continued coverage must also be submitted within the ninety (90) day period. A Pre-Existing Condition exclusion period will not be applied to the newborn.

3. ADOPTED CHILDREN

   Any minor child under the charge, care and control of the Insured named in Schedule A of the certificate whom the Insured has filed a petition to adopt on or after the Effective Date of the certificate will be immediately covered under the Group Policy. Coverage will begin on the date of the filing of a petition for adoption if the Insured applies for coverage within sixty (60) days after the filing of such petition for adoption. For a newborn adoptee, coverage will begin from the moment of birth if the petition for adoption and application for coverage are filed within sixty (60) days after the child's birth. A Pre-Existing Condition exclusion period will not be applied to the adoptee. Coverage for any prospective adoptee will cease upon termination of the application for adoption.

B. TERMINATION OF INSURANCE

1. Coverage for the Insured named in Schedule A of the certificate will terminate upon the earliest of:

   a. the date on which the required premium is not paid, subject to the "Grace Period" provision in Part VIII of the Group Policy and certificate;

   b. the date on which the Insured ceases to be a member of the Association to which the Group Policy is issued;

   c. the death of the Insured;

   d. the date on which You perform an act or practice that constitutes fraud or make an intentional misrepresentation of material fact under the terms of the Group Policy; or

   e. the date on which the Group Policy or all individual health insurance coverage as defined by Public Law 104-191 is terminated in Your state in accordance with Public Law 104-191 and any applicable state law.

2. Coverage for an Eligible Dependent will cease on the earliest of:

   a. the date on which coverage for the Insured named in Schedule A of the certificate terminates as described in paragraph one of this section; or

   b. the last day of the premium month in which a dependent ceases to meet the definition of an Eligible Dependent.

If an identifiable premium is accepted after the termination date for an Eligible Dependent, coverage for that dependent will continue in force until the end of the period for which premium has been paid.

C. CONTINUATION OF COVERAGE

1. TERMINATION OF EMPLOYMENT OR MEMBERSHIP: Any Insured whose coverage under the Group Policy would otherwise terminate due to termination of employment or membership in the Association may continue coverage under the Group Policy as provided herein. To have the right to continue coverage, the Insured must have been covered under the Group Policy, or any it replaced, for at least three (3) months prior to the date coverage would terminate.

   Continuation of coverage shall not be available to an Insured who is eligible for full coverage under any other group coverage, including coverage for any Pre-Existing Conditions the Insured may have.

   An Insured who wishes to continue coverage must submit a written request for continuation to Us within ten (10) days after the termination of employment or membership.

   An Insured who requests continuation of coverage must pay the premium required on a monthly basis in advance, subject to the provisions of Part VIII.A. of the Group Policy and certificate.

   Continuation of coverage shall end upon the earliest of:

   a. one hundred twenty (120) days after continuation of coverage began;

   b. the date on which the required premium is not paid, subject to the "Grace Period" provision in Part VIII.A. of the Group Policy and certificate; or

   c. the date the Group Policy terminates.

   At the termination of the continued coverage, the Insured shall be eligible for a conversion policy, subject to the provisions of Part VI.E. "Medical Benefits Conversion Right".

2. LOSS OF ELIGIBILITY AS AN ELIGIBLE DEPENDENT: If an Eligible Dependent's coverage terminates as set forth in paragraph B.2., of this Part VI of the Group Policy and certificate, due to reaching the limiting age or a change in marital status, the Eligible Dependent may continue coverage without providing evidence of insurability by making the required premium payments for issuance of his or her own certificate and by becoming a dues paying member of the Association to which the Group Policy is issued. The Eligible Dependent must submit a written request for this continuation of coverage within thirty-one (31) days of the date on which coverage would otherwise terminate.

D. EFFECT OF MENTAL OR PHYSICAL HANDICAP ON TERMINATION

An unmarried Eligible Dependent's insurance may be kept in force past the date it would have ended due to age if:

1. prior to reaching that age, the Eligible Dependent is not able to earn a living due to mental or physical handicap; and

2. the Eligible Dependent remains dependent on the Insured named in Schedule A of the certificate for the majority of his or her support.

As evidence that the handicap still exists, written proof will be required, but not more often than once a year. The proof must be submitted in a form required by the Company. The handicap will be considered to have ceased if the required proof is not received when due. Otherwise, insurance of the Eligible Dependent will end when:

1. the handicap ceases; or

2. it would end for reasons other than the Eligible Dependent's age.

E. MEDICAL BENEFITS CONVERSION RIGHT

1. NATURE OF THE CONVERSION RIGHT: This right applies if You lose coverage under the Group Policy except as specified herein. You may convert, without providing evidence of insurability, to a Guaranteed Renewable Conversion Policy offering similar coverage. This right is subject to the terms of this section.

   The premium rate for the conversion policy will be based on Your current age under the converted certificate.

   You may not convert if benefits under the Group Policy cease because:

   a. premium contributions were not paid when due;

   b. benefits are replaced by similar group coverage within thirty-one (31) days; or

   c. termination of coverage is due to a complete withdrawal by the Company from the individual market in the state as allowed under state and federal law.

   To convert, You must submit the following within thirty-one (31) days of termination of coverage:

   a. written application; and

   b. the first premium payment.

2. PERSONS COVERED UNDER A CONVERSION POLICY: Any Insured who was covered under the certificate on the date of termination.

   At Our option, a separate conversion policy will be issued to each Eligible Dependent.

3. FORM OF THE CONVERSION POLICY: The conversion policy will be on a form that is allowed in the state in which it is issued.

   The benefit level of the conversion policy will not exceed the benefit level of the certificate at the time of termination. Benefit levels will take into account:

   a. stated dollar amounts;

   b. co-insurance percentages;

   c. established maximums; and

   d. deductibles.

4. EFFECTIVE DATE OF THE CONVERSION POLICY: The conversion policy will take effect on the day following termination of eligibility for medical benefits under the Group Policy.

5. PREMIUM MODE: The initial conversion premium must be quarterly.

F. EXTENSION OF MEDICAL BENEFITS

If You are Totally Disabled at the time insurance terminates, Your coverage will continue during such Total Disability but only for the bodily Injury or Sickness causing the disability. The maximum period for such coverage is the earlier of the following:

1. the date on which You cease to be Totally Disabled;

2. three (3) months after the date on which insurance coverage would otherwise have terminated; or

3. the date on which You acquire insurance under a replacement plan which provides similar benefits but only if the plan covers the Injury or Sickness causing the disability without limitation.

If You are Hospital confined at the time insurance terminates, coverage will continue until Your Hospital confinement ends or benefits are exhausted, whichever is earlier.

G. MEDICARE ENROLLMENT

If You become enrolled in Medicare at the same time that Your coverage under the Group Policy is in force, continued coverage will be provided only to the extent that the benefits payable by the Group Policy are not also reimbursed by Your Medicare coverage. Your premium rate will be revised for this change in coverage as of the first premium due date after We receive written notice of Your Medicare enrollment.

If in the future, Public Law 104-191 is amended to allow termination of Your coverage upon enrollment in Medicare, We will have the option to take such action.

H. CANCELLATION BY THE INSURED

You may cancel Your coverage under the Group Policy by sending Us a written request. In this event, Your certificate will terminate on the first premium due date following the date We receive Your written request in Our Home Office, and Your coverage will not remain in effect during the grace period described in Part VIII of the Group Policy and certificate. Our liability for a premium refund will be limited to any premium payment We accept or draft from Your bank account in error after the date We receive Your written request to cancel Your coverage. You may not cancel Your coverage in advance of a premium due date to receive a refund of unearned premiums, unless otherwise allowed by the laws of Your state.

PART VII - GENERAL CONTRACT PROVISIONS

A. ENTIRE CONTRACT: The Group Policy (with the application, Your enrollment form, and all attached options and amendments) is the entire contract between the Group Policyholder, You and Us. Any statement made by You, in the absence of fraud, will be considered a representation and not a warranty. After Your certificate has been in force for two (2) consecutive years, any statements, except fraudulent misstatements, made in Your application will not be used to void the certificate. Any statement which You make for the purpose of effecting insurance may not be used to void Your coverage or reduce Your benefits unless it is contained in a written statement signed by You or the primary Insured, a copy of which has been furnished to You or Your beneficiary.

No changes in the Group Policy or the certificate shall be valid unless approved by an executive officer of the Company and such approval be endorsed thereon or attached thereto. No agent has the authority to change the Group Policy or the certificate or to waive any of their provisions.

B. INDIVIDUAL CERTIFICATES: A certificate will be issued to the Insured named in Schedule A of the certificate that describes the provisions of the Group Policy and where the Group Policy may be inspected.

C. CONFORMITY WITH STATE STATUTES: Any provisions of the certificate that are in conflict with the statutes of the state which governs this coverage will be changed or deemed to conform with the minimum requirements of such laws as of the time such laws should or would have been effective as to the certificate.

D. WAIVER OF RIGHTS: If any provision of the Group Policy or the certificate is not enforced, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Group Policy or the certificate.

E. OTHER INSURANCE WITH THIS INSURER: Insurance effective at any one time on You under a like group or individual policy in this Company is limited to the one such policy elected by You, Your beneficiary, or Your estate, as the case may be. All premiums paid on all other such policies from the time the duplication of coverage existed will be returned without interest.

PART VIII - PREMIUM PROVISIONS

A. GRACE PERIOD: After payment of the first premium, a grace period of thirty-one (31) days following a premium due date will be allowed to pay subsequent premiums. During the grace period, Your certificate will remain in force unless written notice is received from You prior to the end of the grace period that the coverage is to be terminated. If You do not pay the premium prior to the expiration of the thirty-one (31) day period from the due date, the certificate will lapse due to non-payment of premium and coverage will cease at 12:00 p.m. on the thirty-first (31st) day. You will be liable for payment of the premium for the period that the coverage remains in force if benefits are paid for Eligible Expenses incurred during the grace period. Such payment will not extend coverage beyond the grace period.

B. REINSTATEMENT: If Your certificate lapses due to non-payment of premium, reinstatement of Your coverage may be considered if You notify Us of Your intention to reinstate. Upon such notice, We will furnish You an application to be completed and submitted along with premiums necessary to pay the certificate to a current status. Your premium payment and Your completed application for reinstatement must be received at Our Home Office at the address shown on page 1 within ninety (90) days after the last day for which premium payment was made. Reinstatement will not be effective unless approved by the Company. At Our option, the approved reinstatement may not include coverage during the lapsed period and premiums would not be charged for this period.

C. MISSTATEMENT OF AGE OR SEX: If Your age or sex has been misstated, there shall be an adjustment of the premium for the certificate, retroactive to Your Effective Date, so that there shall be paid to Us the premium for the coverage at the correct age and sex. The amount of the insurance coverage shall not be affected. Continuation of coverage shall be contingent upon payment of all premium in arrears. Any overpayment of premium by You will be promptly refunded.

D. PREMIUM CHANGES: Your premium rate can be changed at any time by giving thirty-one (31) days written notice to You. Written notice shall be considered effective when We address the notice to Your last known mailing address and deposit the notice, postage paid, into the care and custody of the United States Postal Service. You cannot be singled out for renewal rate increases due to claim loss experience on Your individual certificate.

PART IX - CLAIM PROVISIONS

A. NOTICE OF CLAIM: Written notice of claim must be given to Us within thirty (30) days after the occurrence or commencement of any loss covered by the Group Policy, or as soon thereafter as is reasonably possible. Notice given by You or on Your behalf to Our Home Office with information sufficient to identify You, shall be deemed notice to Us.

B. CLAIM FORMS: When notice of claim is received, You will be sent forms for filing Your claim. If these forms are not given to You at Your last known address within fifteen (15) days, You can meet Our requirements by giving Us a written statement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the "Proof of Loss" provision. Where claims are incurred by a non-insuring parent of a child covered under the Group Policy, claim forms and any other necessary information will be provided for the non-insuring parent to obtain benefits.

C. PROOF OF LOSS: You must furnish Us acceptable written proof of loss within ninety (90) days of Your claim. If it was not possible for You to give proof within the ninety (90) days, Your claim will not be denied for this reason if You send the proof as soon as You can. In any event, You must send Us the proof no later than one (1) year from the time specified, unless You are legally incapacitated.

D. TIME OF PAYMENT OF CLAIMS: Payments for a covered claim will be made to You as they are incurred, within the time frames required by law in Your state of residence.

E. PAYMENT OF CLAIMS: All payments will be made to You, unless You direct otherwise in writing or except as provided herein. Any unpaid claim at Your death may, at Our option, be paid to Your beneficiary or estate. Where covered expenses are incurred by a non-insuring parent of a child that is covered under the Group Policy, benefits will be payable, as appropriate, to the non-insuring parent, a health care provider, or a state or federal agency when required by law.

F. PHYSICAL EXAMINATIONS AND AUTOPSY: We have a right to have You examined, at Our expense, as often as reasonably necessary while a claim is pending. In case of death, We may also have an autopsy performed unless prohibited by law.

G. CLAIMS APPEAL: If Your claim is denied in whole or in part, You will be notified in writing. Within sixty (60) days of receiving this notification, You may request that any portion of the claim for which You believe benefits were wrongly denied be reconsidered. Your request for reconsideration must be in writing, and must include:

1. the name and address of the Insured named in Schedule A of the certificate and the patient;

2. the Certificate Number;

3. the date(s) of service;

4. the claim number from the decline notice;

5. the provider's name; and

6. the reason why the claim should be reconsidered.

You may, within forty-five (45) days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. Written releases may be required, if it is determined that the information is sensitive or confidential. You may also, within forty-five (45) days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

A written decision will be provided to You within sixty (60) days after Your request for review has been received. That written decision will indicate the reasons for the decision and refer to the Group Policy provision(s) on which it was based. In special circumstances, additional time may be necessary to make a decision. You will be informed if this happens but it will never be more than one hundred twenty (120) days from the date of the original declination.

After You receive Our decision and if You disagree with the decision, You may request External Review as described in the following paragraph or arbitration as described in Part X of the Group Policy and certificate.

These claims appeal procedures also apply to any Utilization Review decision which is made as described in Part I of the Group Policy and certificate.

H. RIGHT TO EXTERNAL REVIEW: Within sixty (60) days after the date of receipt of a notice of an Adverse Determination or Final Adverse Determination, You may file a request for an external review with Us.

All requests for external review must be made in writing to National Health Insurance Company at 1901 N. State Highway 360, Grand Prairie, Texas 75050 or Post Office Box 619999, Dallas, Texas 75261-6199.

A request for an external review may not be made until You have exhausted Our Claims Appeal procedure.

An external review decision is binding on both You and Us except to the extent either of Us have other remedies available under applicable federal or state law.

Except in the case of a request for an expedited external review, at the time of filing a request for external review, You must submit to the independent review organization a filing fee of twenty-five dollars ($25.00) along with the information and documentation to be used by the independent review organization in conducting the external review. Upon application by You, the commissioner may waive the filing fee upon a showing of undue financial hardship. The filing fee will be refunded to the person who paid the fee if the external review results in the reversal, in whole or in part, of Our Adverse Determination or Final Adverse Determination that was the subject of the external review. If a request for a standard external review or an expedited external review is filed against Us, We will pay the cost of the independent review organization for conducting the external review and will not charge back the cost of the external review to a health care provider.

You have the right to contact the Commissioner of Insurance for assistance at any time by phoning (800) 852-5494, e-mailing Insurance.Consumers@arkansas.gov, or writing to 1200 West Third Street, Little Rock, Arkansas 72201-1904.

When filing a request for an external review, You will be required to authorize the release of any of Your medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Notice related to an Adverse Determination: You may file a request for an expedited external review at the same time You file a request for an expedited review of an appeal as set forth in Our internal grievance procedure or utilization procedure if:

1. You have a medical condition where the timeframe for completion of an expedited review of an appeal set forth in Our internal grievance procedure or utilization review procedure would seriously jeopardize Your life or health or Your ability to regain maximum function; or

2. the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is "experimental" or

"investigational", and Your treating Physician certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

The independent review organization conducting the external review will determine whether You will be required to complete Our expedited internal grievance procedure or utilization review procedure before it conducts the expedited external review.

If You file an appeal under Our internal grievance procedure or utilization review procedure, and if We have not issued a written decision to You within thirty (30) days following the date You file the appeal with Us for a Pre-Certification claim or within sixty (60) days following the date You file the appeal with Us for a non-Pre-Certification claim, and You have not requested or agreed to the delay, You may file a request for external review and will be considered to have exhausted Our internal grievance procedure or utilization review procedure.

Notice related to a Final Adverse Determination: You may file a request for an expedited external review if:

1. You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function; or

2. if the Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which You received emergency services, but have not been discharged from the facility; or

3. a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, and Your treating Physician certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested health care service or treatment that is the subject of the requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

"Adverse Determination" means a determination by Us that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because the requested health care service does not meet Our requirements for medical necessity, or the requested health care services have been found to be "experimental/investigational".

In order to qualify as an "Adverse Determination" for purposes of external review, the decision must involve treatment, services, equipment, supplies, or drugs that would require Us to expend five hundred dollars ($500.00) or more.

"Adverse Determination" does not include a determination by Us to deny a health care service based upon:

1. an express exclusion in the health benefit plan other than a general exclusion for "medical necessity" or "experimental/investigational";

2. an express limitation in the health benefit plan with respect to the number of visits, treatments, supplies or services for a covered benefit in a given calendar period or over Your lifetime;

3. an express limitation in the health benefit plan with respect to a maximum dollar limitation with respect to a covered benefit in a given calendar period or over Your lifetime;

4. a determination by Us that You are not eligible to be a covered person;

5. a determination by Us that treatment, service, or supplies were requested or obtained by You through fraud or material misrepresentation;

6. the health benefit plan's procedure for determining Your access to a health care provider;

7. illegality of services or the means or methods of administering them;

8. FDA or other government agency determinations, reports, or statements; or

9. licensure, permit or accreditation status of a health care provider.

"Final Adverse Determination" means an Adverse Determination involving a covered benefit that has been upheld by Us at the completion of Our internal grievance procedure or utilization review procedure.

PART X - ARBITRATION OF CLAIM DISPUTES

Any dispute regarding claims processing or administration that has not been resolved after the procedures described in the "Claims Appeal" section of Part IX of the Group Policy and certificate have been followed, shall be resolved through non-binding arbitration. Such arbitration shall be administered under the rules of the American Arbitration Association (AAA). One (1) arbitrator shall decide the dispute, unless all parties agree to have three (3) arbitrators. Unless otherwise agreed by all parties, any arbitrator must be a licensed attorney who has practiced life, health and accident insurance law for at least five (5) years. Unless otherwise agreed by all parties, the arbitrator(s) shall be appointed from a list of qualified persons provided by AAA. Any court having proper jurisdiction over all parties may render judgment based upon the award of the arbitrator(s). All fees and expenses of the arbitration shall be paid by the parties equally, except that each party shall pay the cost of its own attorney, experts, witnesses and the preparation and presentation of its proof. The Federal Arbitration Act shall govern the arbitration. Such arbitration shall be a condition precedent to legal action by the Insured or the Company.

All aspects of the arbitration are confidential. Neither a party, an attorney for a party nor an arbitrator may disclose the evidence, content or results of the arbitration without the prior written consent of all parties.

PART XI - APPEAL AND ARBITRATION OF OTHER DISPUTES

Complaints and disputes other than those involving claims processing or administration will first be handled under the same general procedures as those set forth under Part IX of the Group Policy and certificate regarding "Claims Appeal". If this process does not resolve the complaint or dispute, then the matter will be resolved by non-binding arbitration under the same terms as provided under Part X of the Group Policy and certificate regarding "Arbitration of Claim Disputes".

PART XII - COORDINATION OF BENEFITS (COB)

A. COORDINATION OF BENEFITS: You may have other medical expense coverage in addition to this coverage. If so, the benefits from the "Other Plan" will be considered when Your claim is paid. This may require a reduction of benefits under this coverage so that the combined benefits will not be more than one hundred percent (100%) of Your "Allowable Expenses".

B. ORDER OF COORDINATION: To determine whether Our benefits will be reduced, the order in which the various plans will pay benefits has to be determined. This will be done as follows:

1. a plan with no provision to coordinate with other plans will be considered to pay its benefits before a plan which has such a provision;

2. a motor vehicle accident policy will be considered to pay its benefits before other plans for expenses incurred as a result of a motor vehicle accident;

3. a plan which covers You other than as a dependent will be considered to pay its benefits before a plan which covers You as a dependent;

4. a plan which covers You as a dependent of a person whose birthday occurs earlier in the year will be considered to pay its benefits before a plan which covers You as a dependent of a person whose birthday occurs later in the year; except in the case of separation or divorce, the following rules will apply:

    a. the plan of the parent with custody, who is not remarried, will be considered before the parent without custody;

    b. if the parent is remarried, and has custody of the child, the plan of the step-parent will be considered before the plan of the parent without custody;

    c. if there is a court decree which established financial responsibility for medical or health care expenses with respect to dependent children, the benefits of the plan of the parent with financial responsibility shall be considered before the benefits of any other plan;

5. the primary plan of a retired or laid-off employee who is covered by two (2) employers will be the plan which covers him/her as an active full-time employee; and

6. if 1, 2, 3, 4, or 5 above do not establish the order of payment, the plan under which You have been covered the longest will pay its benefits first. The date You first became a covered member of the group will be used as the oldest date of coverage.

C. OTHER PLAN: "Other Plan" means any other plan of medical expense coverage provided by:

1. group or blanket insurance coverage;

2. group Blue Cross, Blue Shield, other group prepayment coverage or health maintenance organization;

3. coverage under an employer sponsored self-insurance plan;

4. a motor vehicle insurance policy; and

5. coverage provided under any governmental program or required or provided by any statutes, except Medicaid or Medicare.

The term "Other Plan" will not include individual insurance or subscriber contracts, or group or blanket school accident type coverages, or hospital indemnity benefits.

D. ALLOWABLE EXPENSE: "Allowable Expense" means any usual or customary medical expense which is covered under any of the plans involved. An allowable charge to a "Secondary" plan includes the value or amount of any deductible, co-insurance percentage, or amount of

otherwise allowable expenses which were not paid by the "Primary" or first paying plan. Coordination of Benefits will not apply to claims of less than one hundred dollars ($100.00).

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION: Certain facts are needed to apply these COB rules. We may get material facts from each person claiming benefits and also gather material facts from or give them to any other insurance company or health benefit plan administrator with whom We coordinate benefits.

F. FACILITY OF PAYMENT: A payment made under another plan may include an amount which should have been paid under this plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again.

G. RIGHT TO RECOVERY: If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;

2. insurance companies; or

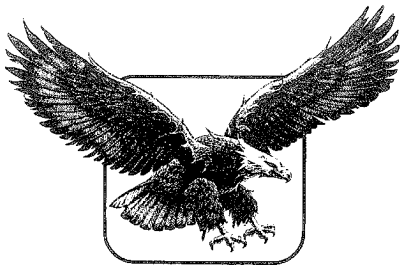
3. other organizations.

H. RIGHT OF SUBROGATION OR REIMBURSEMENT: Upon Our payment of any benefits under this coverage, We shall be subrogated to all of Your rights of recovery against any person or legal entity that may be liable to You, whether in contract or tort, for a claim arising out of or related to Your Injury or Sickness, but only to the extent of the benefits so provided. You shall cooperate with Us and do whatever is necessary for Us to secure Our subrogation rights and to collect Our subrogation claim. You shall not settle any such claim without Our consent or do anything to prejudice Our subrogation rights or Our efforts to collect Our subrogation claim.

As security for Your obligations to Us, You grant Us a lien on any sum of money that You may recover by settlement, judgment or otherwise, from any person or legal entity for a claim arising out of or related to Your Injury or Sickness. You agree that out of any such recovery, We shall receive the first disbursement for the amount of the benefits that We paid, regardless of whether You have been fully compensated and before payment of any other existing claims, including any claim by You for general damages. If any applicable law does not allow subrogation, You agree to reimburse Us from any such recovery for any benefits that We paid under this coverage, before applying the recovery to any other existing claim.

In the event You recover from the third party, reasonable cost of collection and attorney's fees thereof shall be assessed against You and Us in the proportion each benefits from the recovery.

GROUP HOSPITAL/SURGICAL/MEDICAL
CERTIFICATE OF COVERAGE
NATIONAL HEALTH INSURANCE COMPANY



P.O. Box 619999
Dallas, Tx 75261-6199

(Referred to in this Certificate as the Company, We, Us, Our)

This certificate is issued as evidence of coverage under the Group Policy for the Insured named in Schedule A and all covered Eligible Dependents. This certificate describes the benefits and other important provisions of the Group Policy. The Group Policy controls all the terms of the insurance coverage and may be inspected at the office of the Group Policyholder during regular business hours.

PLEASE READ THIS CERTIFICATE CAREFULLY.

Please review the copy of the application which is attached to this certificate. Write to Us at the address shown above if any information is not correct or complete. The application is a part of the insurance contract and an incorrect application may cause coverage to be voided or a claim to be reduced or denied.

To present inquiries, request information about the coverage, or to obtain assistance in resolving a complaint, contact Our Customer Service Department at [1-800-237-1900]. If a problem is not resolved, You may also write to the Department of Insurance in Your state.

IMPORTANT NOTICE: This insurance coverage contains requirements for Pre-Certification of Hospital confinements and outpatient surgery. Please refer to Part I of this Certificate for details. Benefit levels for most expenses vary between Network Providers and Non-Network Providers. Please refer to Parts II and III of this certificate for details.

RIGHT TO RETURN CERTIFICATE WITHIN TEN (10) DAYS: If for any reason You are not satisfied with this insurance certificate, You may return it to Us within ten (10) days after the date You receive it. If You return the certificate to Us within the ten (10) day period, the premium You paid will be promptly refunded and the certificate will be void as if it were never issued.

Signed at Our Home Office, Grand Prairie, Texas.

Secretary President

GROUP INSURANCE CERTIFICATE - NON-PARTICIPATING

COORDINATION OF BENEFITS INCLUDED - SEE PART XII

INDEX

SCHEDULE A

GROUP POLICYHOLDER:	[ABC ASSOCIATION]
NAME OF INSURED:	[John Doe]
NOTE:	COVERED ELIGIBLE DEPENDENTS, IF ANY, ARE NAMED IN THE APPLICATION ATTACHED HERETO.
ISSUE STATE:	[XX]
CERTIFICATE NUMBER:	[XXXXXXXXX]
GROUP POLICY NUMBER:	[HSMP-ABC]
EFFECTIVE DATE:	[August 1, 2009]
INITIAL TERM EXPIRES:	[September 1, 2009]
AGGREGATE AMOUNT MAXIMUM FOR EACH INJURY OR SICKNESS:	[$2,000,000]
LIFETIME MAXIMUM PER FAMILY:	[$10,000,000]
CALENDAR YEAR DEDUCTIBLE:	
IN-NETWORK	[$2,000 - $25,000]
OUT-OF-NETWORK	[$4,000 - $27,000]
BENEFIT PERCENTAGE:	
IN-NETWORK	[80%] [70%] [60%] [50%]
OUT-OF-NETWORK	[60%] [50%] [50%] [50%]
CO-INSURANCE PERCENTAGE:	
IN-NETWORK	[20%] [30%] [40%] [50%]
OUT-OF-NETWORK	[40%] [50%] [50%] [50%]
CO-INSURANCE MAXIMUM:	
IN-NETWORK	[$10,000]
OUT-OF-NETWORK	[$10,000 - $25,000]
ENHANCED OUTPATIENT MEDICAL BENEFIT DEDUCTIBLE:	
IN-NETWORK	[$1,000 - $10,000]
OUT-OF-NETWORK	[$2,000 - $11,000]
INITIAL PREMIUM:*	[$255.00]
RENEWAL PREMIUMS:* (SUBJECT TO CHANGE)	[$255.00]

* Premium amounts do not include administration fees or membership dues, if applicable.

This insurance is effective at 12:01 a.m. in the Issue State and on the Effective Date shown above and will continue according to the terms of the Group Policy if:

(1) the Insured is eligible for coverage under the Group Policy; and
(2) the required premiums have been paid.

NOTICE

Customer Service Department
National Health Insurance Company
Post Office Box 619999
Dallas, Texas 75261-6199
(800)237-1900

Agent's Name, Address, and Telephone Number:

Please see the bottom portion of page 4 of your application which is attached to the policy/certificate for the name of your agent. Call our toll-free number above if you should require the agent's address and/or telephone number.

If we at National Health Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact the Consumer Services Division of the Arkansas Department of Insurance at:

1200 West Third Street
Little Rock, Arkansas 72201-1904
(800) 852-5494 or (501) 371-2640
insurance.consumers@arkansas.gov

PART I - UTILIZATION SERVICES

Our UTILIZATION SERVICES Division provides a comprehensive, coordinated program that seeks to assure the highest quality medical care by combining Utilization Review, Second and Third Surgical Opinions, Pre-admission Testing and Case Management of catastrophic conditions.

FOR ALL UTILIZATION SERVICES, YOU OR YOUR PROVIDER MUST CALL [1-800-237-1900]. Emergency Hospital confinements that occur outside normal business hours must be reported within forty-eight (48) hours or on the first business day after admission.

A. UTILIZATION REVIEW

The goal of Our Utilization Review program is for You to receive necessary and appropriate treatment while avoiding unnecessary expenses when a Hospital confinement or outpatient surgical procedure is being considered. All review services are conducted by professional consultants such as registered nurses and social workers who have access to a panel of Physicians, advisors, and/or a Medical Director.

Utilization Review consists of the Pre-Certification of all non-emergency Hospital admissions or outpatient surgical procedures before services are provided, concurrent stay review, and discharge planning.

Utilization Review is not intended as a substitute for the medical judgment of an attending Physician or any other health care provider. However, if a particular treatment is not Pre-Certified when required, it will not be eligible for maximum benefits.

All Utilization Review decisions may be appealed as described in Part IX of the Group Policy and certificate regarding "Claims Appeal" and Part X regarding "Arbitration of Claim Disputes".

1. PRE-CERTIFICATION

   Pre-Certification does not guarantee that benefits will be paid. Payment of benefits will be determined by the Company in accordance with and subject to all of the terms, provisions, limitations, and exclusions of Your coverage under the Group Policy.

   Before You enter a Hospital on a non-emergency basis or schedule an outpatient surgical procedure, Our Utilization Services Division will, in conjunction with Your Physician, review the proposed treatment for medical necessity and appropriateness. A non-emergency Hospital confinement is one which can be scheduled in advance without endangering the health of the patient.

   The Pre-Certification process is set in motion by a telephone call from either You or Your provider to Our Utilization Services Division at the number specified within the second paragraph of this Part I section of the Group Policy and certificate. The following information is required:

   a. name, social security number, and address of the primary Insured;

   b. name of the Insured patient and relationship to the primary Insured;

   c. certificate or ID number;

   d. name and telephone number of the attending Physician;

e. name and address of the Hospital and the proposed date of admission; and

f. diagnosis and/or type of procedure (including outpatient surgery).

If a condition requires an emergency admission to a Hospital, You (or Your representative), the Hospital or the attending Physician must contact Our Utilization Services Division within forty-eight (48) hours or on the first business day after admission.

If the required Pre-Certification procedures are not followed, ELIGIBLE EXPENSES FOR ALL PROVIDERS WILL BE REDUCED BY THIRTY PERCENT (30%). For each Hospital confinement, Our personnel will determine the number of days of confinement which will be authorized for payment. If charges are incurred for days of confinement that were not authorized, NO BENEFITS WILL BE PAYABLE FOR THE UNAUTHORIZED DAYS.

Pre-Certification is valid for thirty (30) days after the confinement or surgical procedure is authorized. If the treatment does not occur as planned, You or the provider must contact Us again to renew the Pre-Certification. If this renewal procedure is not followed, ELIGIBLE EXPENSES FOR ALL PROVIDERS WILL BE REDUCED BY THIRTY PERCENT (30%).

Pre-Certification is not required for Hospital admissions for maternity that do not exceed forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean section, excluding the date of delivery. Maternity stays in excess of these maximums must be requested by Your attending Physician. NO BENEFITS WILL BE PAID FOR EXCESS UNAUTHORIZED DAYS.

2. CONCURRENT STAY REVIEW AND DISCHARGE PLANNING

Our Utilization Services Division will monitor Your Hospital stay and coordinate with Your attending Physician, and the Hospital, either Your scheduled release from the Hospital or an extension of the Hospital admission. If Your attending Physician feels it is Medically Necessary for You to remain in the Hospital for a greater length of time than originally authorized, the attending Physician must request the additional days prior to the end of the Pre-Authorized confinement. NO BENEFITS WILL BE PAYABLE FOR UNAUTHORIZED DAYS.

B. SECOND AND THIRD SURGICAL OPINIONS

Some surgical procedures are performed unnecessarily or inappropriately. In many instances, surgery is only one of several treatment options. In other situations, surgery will not be of any benefit to the patient. In some cases, surgery can be performed on an outpatient basis.

As medical practices change, specific surgical procedures requiring an additional opinion will also change. Our Utilization Services Division will determine whether a second surgical opinion will be required. For those procedures requiring additional opinions, the additional consultations must be with Physicians who are board certified specialists in the area involved and must not have any financial association with the surgeon recommending the surgery.

If a second surgical opinion does not confirm the need for surgery, then a third opinion will be required. If the third opinion does not confirm the necessity for surgery, all Eligible Expenses will be paid if You desire the procedure, subject to all other terms of the coverage provided under the Group Policy. Second and third consultations will be considered as Eligible Expenses and will not be subject to the Calendar Year Deductible or Co-Insurance requirements.

FAILURE TO OBTAIN REQUIRED ADDITIONAL OPINIONS WILL RESULT IN A THIRTY PERCENT (30%) REDUCTION IN THE ELIGIBLE EXPENSES FOR THE SURGICAL PROCEDURE.

C. ROUTINE PRE-ADMISSION TESTING

Benefits will be payable for a covered Injury or Sickness for routine pre-admission laboratory tests and x-ray examinations when performed on an outpatient basis within seven (7) days prior to a Hospital admission, subject to satisfaction of the Calendar Year Deductible and Co-Insurance requirements. The procedures must be required by the condition causing the Hospital confinement and must be performed in place of the same tests and examinations that would otherwise be conducted during the Hospital confinement. Charges incurred will be considered as Eligible Expenses even if the results reveal that the condition requires medical treatment prior to Hospital admission or that the Hospital admission is not required.

D. CASE MANAGEMENT OF CATASTROPHIC CONDITIONS

When a catastrophic Sickness or Injury requires long term care, after being stabilized in a Hospital, You can possibly be discharged from the Hospital into a more cost effective care setting while still maintaining a high quality level of care. The Case Management program is designed for those situations which involve a large cash outlay for expenses that ordinarily would not be covered under the Group Policy.

Case Management is utilized only when:

1. the catastrophic Sickness or Injury occurs while both You and Your Sickness or Injury are covered under the Group Policy;

2. You have been hospitalized and Your attending Physician determines that the condition is stabilized;

3. You continue to require that Your care be managed but You need not be hospitalized to receive the care;

4. Your placement in a new care setting is contemplated, entailing costs which are not ordinarily reimbursable under the Group Policy; and

5. the Company, the Case Manager, Your attending Physician, and Your legal representative agree to the alternate treatment plan.

The Case Manager will coordinate and implement Your Case Management program and will provide information on resources and suggestions for proper treatment plans. Once an agreement has been reached, the Group Policy will reimburse for all expenses incurred, even if those expenses would normally not be considered as Eligible Expenses, subject to the Aggregate Amount Maximum and the Lifetime Maximum amount.

Case Management is a voluntary service with no reduction of benefits or other penalties attached if You choose not to participate.

PART II - BENEFIT LEVELS

The Company accesses Preferred Provider Networks consisting of Hospitals, Physicians, and other specialty types of health care providers and facilities in which the participating providers (hereafter called "Network Providers") have agreed to provide services at a discounted rate to the Company's Insureds. Benefits will be based on Your choice of a health care provider. You will

choose whether to use a Network Provider at the time that services are needed. There is no requirement to commit in advance to utilizing a Network Provider.

A Network Provider Directory will be made available to You which will list all Network Providers in Your general geographic area. The Company will periodically update this information, but since Network Providers can change, You should call [1-800-237-1900] or visit our website at [www.nhic.com] to make sure that the provider is still a Network Provider before You receive medical services.

The following provisions apply to all benefits provided by the Group Policy with the exception of the Enhanced Outpatient Medical Benefit.

A. CALENDAR YEAR DEDUCTIBLES

IN-NETWORK: The In-Network Calendar Year Deductible amount is shown in Schedule A of the certificate. You can meet this Deductible by incurring Eligible Expenses for services received from either Network or Non-Network Providers.

After three (3) individual In-Network Calendar Year Deductibles have been satisfied by any three (3) Insureds within a family, additional In-Network Calendar Year Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

OUT-OF-NETWORK: The Out-of-Network Calendar Year Deductible amount is shown in Schedule A of the certificate. You can meet this Deductible by incurring Eligible Expenses only from Non-Network Providers.

After three (3) individual Out-of-Network Calendar Year Deductibles have been satisfied by any three (3) Insureds within a family, additional Out-of-Network Calendar Year Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

B. BENEFIT AND CO-INSURANCE PERCENTAGES

After satisfaction of the Calendar Year Deductible requirement(s), Eligible Expenses will be paid at the Benefit Percentage shown in Schedule A of the certificate for either In-Network or Out-of-Network services, based on Your choice of provider. You will be responsible for the Co-Insurance percentage shown in Schedule A of the certificate for either In-Network or Out-of-Network services, based on Your choice of provider.

C. CO-INSURANCE MAXIMUMS

The Co-Insurance Maximum amounts are shown in Schedule A of the certificate. There is an In-Network Co-Insurance Maximum amount and an Out-of-Network Co-Insurance Maximum amount. You can meet both these amounts simultaneously with Eligible Expenses incurred for services received from either a Network or a Non-Network Provider, up to the amount of the In-Network Co-Insurance Maximum. After the In-Network Co-Insurance Maximum amount has been satisfied, only Eligible Expenses incurred for services received from a Non-Network Provider can be used to satisfy any remaining Out-of-Network Co-Insurance Maximum amount.

After You meet the In-Network Deductible and In-Network Co-Insurance Maximum amount, additional Eligible Expenses incurred during that same Calendar Year, for services received from a Network Provider, will not be subject to Co-Insurance.

After You meet the Out-of-Network Deductible and Out-of-Network Co-Insurance Maximum amount, additional Eligible Expenses incurred during that same Calendar Year, for services received from a Non-Network Provider, will not be subject to Co-Insurance.

Co-Insurance Maximum amounts apply to each Insured each Calendar Year even though a condition or claim may continue from one (1) Calendar Year to the next. After three (3) Insureds within a family have met the In-Network Co-Insurance Maximum amount in a Calendar Year, additional Eligible Expenses of any Insured within the same family will not be subject to Co-Insurance for the remainder of that same Calendar Year.

This provision applies to all benefits where there is a differential between the amounts payable for services received from Network versus Non-Network Providers:

D. MEDICAL EMERGENCY SERVICES

If You cannot reasonably access a Network Provider, the following emergency care services will be reimbursed at the Network Provider level of benefits until You can reasonably be expected to transfer to a Network Provider:

1. a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital that is necessary to determine whether a Medical Emergency condition exists;

2. necessary emergency care services, including the treatment and stabilization of a Medical Emergency condition; and

3. services originating in a Hospital emergency facility following treatment or stabilization of a Medical Emergency condition.

PART III - ELIGIBLE EXPENSES

Subject to the provisions set forth in this section and all other terms of the Group Policy, charges for the services described in the following paragraphs will qualify as Eligible Expenses and will be considered for payment. All benefits payable are subject to the Aggregate Amount Maximum of [two million dollars ($2,000,000.00)] per Injury or Sickness and a Lifetime Maximum amount of [ten million dollars ($10,000,000.00)] for all combined claim payments for all Insureds.

Eligible Expenses must meet the following requirements in order to be considered for payment:

1. any Injury is sustained or first occurs on or after the Effective Date of Your coverage under the Group Policy and while Your coverage is in force;

2. any Sickness first Manifests itself after the Effective Date of Your coverage under the Group Policy and while Your coverage is in force;

3. the Eligible Expense is incurred while Your coverage under the Group Policy is in force; and

4. any loss for any Pre-Existing Condition, which is not excluded by endorsement or by name or specific description, occurs after You have been covered for twenty-four (24) months under the Group Policy.

A. INPATIENT HOSPITAL EXPENSES

If You receive treatment in a Hospital on an inpatient basis for a covered Injury or Sickness, Eligible Expenses under this benefit will be the Usual and Customary Charges for Hospital expenses incurred in the course of Your treatment, excluding:

1. ambulance charges (covered under separate benefit paragraph);

2. charges for Hospital room and board in excess of the Hospital's most prevalent semi-private room rate (except for Intensive Care Unit charges);

3. charges for personal, comfort, or convenience items such as telephone, television, or radio;

4. take home items, including but not limited to drugs and medicines;

5. charges for any other items or services which are not Medically Necessary; and

6. charges for any days of confinement not authorized in the Pre-Certification or Concurrent Stay Review process.

B. INPATIENT MEDICAL EXPENSES

If You receive treatment in a Hospital on an inpatient basis for a covered Injury or Sickness, Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for the items of medical expense listed herein. The eligible items of expense are:

1. Surgeons' fees for surgical operations;

2. Assistant Surgeons' fees for surgical operations;

3. Anesthesiologists' fees;

4. Physicians' Visits at Hospital (not payable to surgeon or assistant surgeon);

5. Pathologists' fees;

6. Radiologists' fees; and

7. Physiotherapists' fees.

C. OUTPATIENT SURGICAL EXPENSES

If You have a surgical operation that is performed on an outpatient basis in a Physician's office or clinic, Hospital, or ambulatory surgery facility due to a covered Injury or Sickness, the Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for the items of expense listed herein. The eligible items of expense are:

1. Hospital or ambulatory surgery facility fees;

2. Surgeons' fees for surgical operations;

3. Assistant Surgeons' fees for surgical operations;

4. Anesthesiologists' fees;

5. Pathologists' fees; and

6. Radiologists' fees.

D. WELL CHILD CARE

If You incur expenses for preventive and primary care services provided by a Physician or under the supervision of a Physician during unlimited visits for Eligible Dependent children up to the

age of twelve (12) and during three (3) visits per Calendar Year for children ages twelve (12) to twenty-one (21), Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for such services. Preventive and primary care services shall include physical examinations, measurements, sensory screening, neuropsychiatric evaluation, developmental screening and anticipatory guidance. Eligible Expenses will also include hereditary and metabolic screening at birth, urinalysis, tuberculin tests and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy, hypothyroidism, phenylketonuria (PKU), galactosemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas. The Usual and Customary Charges for immunization services, without application of the Calendar Year Deductible or Co-Insurance, will also be considered as Eligible Expenses under this benefit.

In addition, Eligible Expenses under this benefit include the Usual and Customary Charges incurred for routine Hospital nursery care and pediatric charges for a child born to the Insured named in Schedule A of the certificate on or after the Effective Date of the certificate. Benefits will be payable for up to five (5) full days in a Hospital nursery or until the parent is discharged from the Hospital following the birth of the child, whichever is the lesser period of time. Eligible Expenses for the child will be subject to the Calendar Year Deductible and Co-Insurance for the child.

E. DIABETES SERVICES

If You have been diagnosed with insulin-dependent, insulin-using, gestational, or non-insulin using diabetes or elevated blood glucose levels resulting from another medical condition, Eligible Expenses under this benefit will be the Usual and Customary Charges for Medically Necessary equipment, supplies, and services which are provided or prescribed by a Physician in the course of Your treatment.

Eligible Expenses will also include the Usual and Customary Charges for outpatient self-management training and education, including medical nutritional therapy when prescribed by Your Physician.

F. HOME HEALTH CARE

If You incur expenses for Home Health Care, such expenses will qualify as Eligible Expenses if:

1. expenses are incurred beginning within fourteen (14) days after being discharged from a Hospital where treatment was received for a covered Injury or Sickness;

2. Your Physician certifies that without Home Health Care, You would have to remain Hospital confined to receive proper treatment;

3. You continue to need care and treatment in Your place of residence; and

4. Your Physician submits a Home Health Care plan in writing to the Company.

Eligible Expenses under this benefit will be the Usual and Customary Charges for Home Health Care for the following services, to a maximum of [twenty thousand dollars ($20,000.00)] per Calendar Year per Insured.

Skilled Nursing Care
Physical Therapy
Occupational Therapy
Medical/Social Work
Nutritional Services
Respiratory Therapy
Speech Therapy
Medical Appliances and Equipment
Prescription Drugs
Laboratory Services
Home Health Aid Visits

Home Health Care does not include and no benefits will be payable for custodial care or services or supplies not included in the Home Health Care plan submitted by Your Physician.

The Company's Case Management Services will be available to You and Your family. There is no reduction of benefits or other penalties attached if You choose not to utilize these services.

G. HOSPICE CARE

If You should require Hospice Care for a covered Injury or Sickness, Eligible Expenses under this benefit will be the Usual and Customary Charges for Hospice Care to a lifetime maximum per Insured of the lesser of one hundred eighty (180) days or [ten thousand dollars ($10,000.00)], if:

1. Your Physician certifies that Your life expectancy is less than six (6) months;

2. Your Physician recommends a Hospice Care program for Your benefit and that of Your immediate family;

3. the services and supplies are ordered by a Physician who directs the Hospice Care program; and

4. the services and supplies are provided to reduce or abate pain or other symptoms of distress and to meet the stresses of dying.

The Company's Case Management Services will be available to You and Your family. There is no reduction of benefits or other penalties attached if You choose not to utilize these services.

H. AMBULANCE

If You require transportation by ambulance for treatment of a covered Injury or Sickness, Eligible Expenses under this benefit will be such ambulance transportation expenses to a maximum of [five hundred dollars ($500.00)] per Insured per Calendar Year.

I. WOMEN'S HEALTH AND CANCER RIGHTS

The United States Congress passed legislation effective October 21, 1998 which requires individual and group health plans to provide reconstructive surgery benefits if the plan normally provides medical and surgical benefits for a mastectomy. The required coverage consists of:

1. reconstruction of the breast on which the mastectomy was performed; and

2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. prostheses and physical complications from all stages of a mastectomy including lymphedemas.

These benefits must be provided in a manner determined in consultation with the attending provider and the patient. The coverage will be subject to the same Deductible, Co-Insurance, and other benefit provisions as for similar types of expenses covered under the plan for other Sicknesses. These benefits will not duplicate any other benefits payable under the plan. Coverage provided will be in accordance with federal and state law and applicable regulations.

J. ENHANCED OUTPATIENT MEDICAL BENEFIT

This paragraph is NOT SUBJECT to the Calendar Year Deductibles, Benefit Percentages, Co-Insurance Percentages, or Co-Insurance Maximums shown in Schedule A of the certificate. Separate Deductible amounts, benefit percentages, and co-insurance maximum apply to this paragraph. Eligible Expenses incurred under this benefit may not be used to

satisfy the Calendar Year Deductibles or Co-Insurance Maximums shown in Schedule A of the certificate.

The Enhanced Outpatient Medical Benefit Deductible amounts are shown in Schedule A of the certificate and apply to each Insured each Calendar Year. There is an In-Network Deductible amount and an Out-of-Network Deductible amount. These Deductible amounts may be satisfied only with Eligible Expenses incurred under the Enhanced Outpatient Medical Benefit.

You can meet the In-Network Enhanced Outpatient Medical Benefit Deductible amount by incurring Eligible Expenses for services received from either Network or Non-Network Providers. After three (3) total In-Network Deductibles have been satisfied by any three (3) Insureds within a family, additional In-Network Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

You can meet the Out-of-Network Enhanced Outpatient Medical Benefit Deductible amount by incurring Eligible Expenses only from Non-Network Providers. After three (3) total Out-of-Network Deductibles have been satisfied by any three (3) Insureds within a family, additional Out-of-Network Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

Eligible Expenses are the Usual and Customary Charges incurred for THE FOLLOWING outpatient services/treatments which You receive in a Physician's office or clinic, Hospital, or ambulatory surgery facility due to a covered Injury or Sickness. After the Deductible requirement(s) have been met from Eligible Expenses, benefits will be paid at [eighty percent (80%)] of Usual and Customary Charges for services received from a Network Provider or [sixty percent (60%)] of Usual and Customary Charges for services received from a Non-Network Provider for the next [ten thousand dollars ($10,000)] of Eligible Expenses. Thereafter, during that same Calendar Year, Eligible Expenses will be paid at [one hundred percent (100%)] of Usual and Customary Charges. You are responsible for the Deductible requirement(s), Your portion of Eligible Expenses incurred after the Deductible is satisfied, and any non-covered charges. These benefit payment provisions apply to the expenses incurred for each Insured individually.

Pathology (Lab. Services)
Radiology (X-Rays)
Upper/Lower G.I. Series
CAT Scans
Magnetic Resonance Imaging
Nerve Conduction Studies
Emergency Room Facility Fees
Non-Surgical Anesthesia
Casts, Splints & Braces
Surgical Dressings
Central Supplies
Kidney Dialysis
Chemotherapy Treatments
Cobalt Treatments
Irradiation Treatments
Ultrasound
Sonograms
Myelograms
Pyelograms
Angiograms
Electrocardiograms
Electroencephalograms
Electromyograms
Pneumoencephalograms
Durable Medical Equipment - Maximum of $2,500 per Insured per Calendar Year.
Physical Therapy - Not to exceed the lesser of 25 treatments or $2,000 per Insured per Calendar Year.
Occupational Therapy - Not to exceed the lesser of 25 treatments or $2,000 per Insured per Calendar Year.

Total benefits provided will be **LIMITED TO THOSE SERVICES LISTED ABOVE** and shall not exceed [two hundred fifty thousand dollars ($250,000.00)] of Eligible Expenses per Insured per Calendar Year. Kidney dialysis must be received in a Medicare approved dialysis center. This benefit does not provide coverage for Physician fees (including but not limited to Physician fees for office or clinic visits, routine physical exams, or surgery), prescription drugs or any other service not specifically listed.

K. MAMMOGRAPHY AND CYTOLOGIC SCREENING

This benefit is NOT SUBJECT to satisfaction of the Calendar Year Deductibles or Co-Insurance.

If You receive any of the following services, Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for such services. The eligible services are:

1. an annual cervical cytologic screening for a female Insured;

2. any cervical cytologic screening for a female Insured which her Physician certifies to be Medically Necessary;

3. a baseline mammogram and annual mammograms thereafter for a female Insured; and

4. any mammogram for a female Insured which is certified to be Medically Necessary by her Physician or which is recommended by her Physician where such Insured or her mother or sister has had a history of breast cancer.

Eligible Expenses for cervical cytologic screening include only the laboratory charges for the test and do not include the Physician office visit charge.

L. PROSTATE CANCER SCREENING

This benefit is NOT SUBJECT to satisfaction of the Calendar Year Deductibles.

Eligible Expenses under this benefit will be the Usual and Customary Charge for prostate cancer screening performed by a Physician in accordance with the National Comprehensive Cancer Network guidelines in effect as of January 1, 2009 for the ages, family histories, and frequencies referenced in such guidelines. If a Physician recommends that You undergo a prostate specific antigen blood test, We may not deny coverage for the test on the basis of a previous negative digital rectal examination.

M. TREATMENT OF CATASTROPHIC METABOLIC DISORDERS

If You have been diagnosed with a Catastrophic Metabolic Disorder, Eligible Expenses under this benefit will be charges incurred for Medically Necessary amino acid modified preparations, Medical Foods, Low Protein Modified Food Products and any other special dietary products and formulas prescribed and administered by a Physician for the therapeutic treatment of Catastrophic Metabolic Disorders which are in excess of two thousand four hundred dollars ($2,400.00) in a Calendar Year.

"Catastrophic Metabolic Disorder" means phenylketonuria (PKU), galactosemia, organic acidemias, and disorders of amino acid metabolism.

"Inherited Metabolic Disease" means a disease caused by an inherited abnormality of body chemistry.

"Low Protein Modified Food Product" means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease.

"Medical Food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

N. MUSCULOSKELETAL DISORDERS OF THE FACE, NECK OR HEAD

Eligible Expenses under this benefit are the Usual and Customary Charges incurred for surgical or nonsurgical medical treatment of a musculoskeletal disorder affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder. Coverage will be provided for Medically Necessary diagnosis and treatment of these conditions regardless of cause and whether prescribed or administered by a dentist or a Physician. Benefits will be payable only to the same extent as for any other Sickness covered under the Group Policy.

O. COLORECTAL CANCER SCREENING

Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for Colorectal Cancer Screening for Insureds who are:

1. fifty (50) years of age or older;

2. less than fifty (50) years of age but who are at High Risk for Colorectal Cancer; or

3. Symptomatic of Colorectal Cancer as determined by a Physician.

Benefits for Colorectal Cancer Screening services will include an examination of the entire colon including the following examinations and laboratory tests:

1. an annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;

2. a double-contrast barium enema every five (5) years; or

3. a colonoscopy every ten (10) years.

The Insured will determine the choice of screening strategies in consultation with a Physician. Benefits will also include any additional medically recognized screening tests for colorectal cancer required by the Director of the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations.

This benefit will also include coverage for follow-up screenings based on the following guidelines:

1. if an initial colonoscopy was normal, a follow-up screening after ten (10) years;

2. if the Insured had one (1) or more neoplastic polyps or adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, a follow-up screening after three (3) years;

3. if the Insured had a single tubular adenoma of less than one centimeter (1 cm), a follow-up screening after five (5) years; or

4. if the Insured had large sessile adenomas greater than three centimeters (3 cm), especially if removed in a piecemeal fashion, a follow-up screening in six (6) months or until complete polyp removal is verified by colonoscopy.

"High Risk for Colorectal Cancer" means:

1. the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy;

2. a family history of colorectal cancer in close relatives such as parents, brothers, sisters, or children;

3. genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis;

4. a personal history of colorectal cancer, ulcerative colitis, or Crohn's disease;

5. the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; or

6. any additional or expanded definition of "High Risk for Colon Cancer" as recognized by medical science and determined by the Director of the Division of Health of the Department of Health and Human Services in consultation with the University of Arkansas for Medical Sciences.

"Symptomatic of Colorectal Cancer" includes:

1. bleeding from the rectum or blood in the stool; or

2. a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

P. SPEECH OR HEARING IMPAIRMENT

Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for the necessary care and treatment of loss or impairment of speech or hearing. "Loss or Impairment of Speech or Hearing" shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of the provider's area of certification.

This benefit will include coverage for a hearing aid purchased from a professional licensed in the state of Arkansas to dispense a hearing aid. The maximum benefit amount payable for a hearing aid is one thousand four hundred dollars ($1,400.00) per ear in a three year period and is not subject to Deductible or Co-Insurance requirements.

"Hearing aid" means an instrument or device, including repair and replacement parts, that:

1. is designed and offered for the purpose of aiding persons with or compensating for impaired hearing;

2. is worn in or on the body; and

3. is generally not useful to a person in the absence of a hearing impairment.

Q. ORTHOTIC DEVICES/SERVICES AND PROSTHETIC DEVICES/SERVICES

Eligible Expenses under this benefit will be eighty percent (80%) of Medicare allowable charges as defined by the Center for Medicare and Medicaid Services Healthcare Common Procedure Coding System as of January 1, 2009 or as later revised, for the following Medically Necessary items prescribed and provided by a Physician:

1. an Orthotic Device;

2. an Orthotic Service;

3. a Prosthetic Device; and

4. a Prosthetic Service.

This benefit will include Medically Necessary replacement once every three (3) years unless more frequent replacement is Medically Necessary. Coverage will include replacement or repair necessitated by anatomical change or normal use of an Orthotic or Prosthetic Device unless the repair or replacement is due to misuse or loss. If We deny or limit coverage under this benefit based on lack of Medical Necessity, External Review is available to You as described in Part IX.H. of the Group Policy and certificate.

"Orthotic Device" means an external device that is intended to restore physiological function or cosmesis to a patient and is custom made, fitted, or adjusted for the patient. Orthotic Device does not include a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that is carried in stock by the seller and sold without therapeutic modification and has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

"Orthotic Service" means the evaluation and treatment of a condition that requires the use of an Orthotic Device.

"Prosthetic Device" means an external device that is intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and that is custom made, fitted, or adjusted for the patient. Prosthetic Device does not include an artificial eye, a dental appliance, a cosmetic device such as eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

"Prosthetic Service" means the evaluation and treatment of a condition that requires the use of a Prosthetic Device.

PART IV - EXCLUSIONS AND LIMITATIONS

No payment will be made for claims resulting in or from:

1. a Pre-Existing Condition, which is not excluded by endorsement or by name or specific description, unless the expense is incurred after You have been covered for more than twenty-four (24) months under the Group Policy, excluding newborns and adoptees as provided in Part VI of the Group Policy and certificate;

2. any Injury that was sustained prior to Your Effective Date of coverage under the Group Policy;

3. normal childbirth;

4. prenatal care;

5. Mental or Emotional Disorders, unless specifically provided in the Group Policy due to state mandates and described in the certificate;

6. treatment for alcohol or chemical substance use, abuse, or dependency or illegal drug use or experimentation, unless specifically provided in the Group Policy due to state mandates and described in the certificate;

7. any loss incurred where a contributing factor to the loss was You being Intoxicated or under the influence of any substance which has the capacity to disturb Your mental, emotional, or physical faculties, unless administered on the advice of a Physician;

8. any expenses which exceed the Usual and Customary Charges;

9. any expenses incurred which are not Medically Necessary;

10. aviation (while acting as a pilot or crew member);

11. war or act of war (declared or undeclared);

12. participation in a felony, riot or insurrection;

13. service in the armed forces or units auxiliary thereto (upon notice of Your entry into the armed forces or units auxiliary thereto, You will receive a partial refund of unearned premiums, if any);

14. suicide or intentionally self-inflicted harm;

15. cosmetic surgery, except that surgery resulting from a covered Injury or covered Sickness and reconstructive surgery because of congenital disease or anomaly which has resulted in a functional defect of an Eligible Dependent child born to or placed for adoption with the Insured named in Schedule A of the certificate on or after its Effective Date;

16. breast reduction or augmentation even if Medically Necessary, unless due to reconstructive surgery which is needed as a result of a mastectomy performed due to a diagnosis of breast cancer;

17. dental care or treatment, except that dental treatment caused by an Accidental Injury;

18. weight loss procedures even if Medically Necessary;

19. voluntary abortions, sterilization procedures, or reversals of sterilization procedures;

20. penile implants even if Medically Necessary;

21. sex transformation procedures, hormones for such treatment and charges for related psychiatric care or counseling;

22. infertility treatment including but not limited to artificial insemination, in vitro fertilization, or embryo transfer procedures;

23. experimental treatment or experimental surgery not recognized by the American Medical Association, or considered to be experimental or investigational by any appropriate health care technological assessment body established by a state or federal government;

24. Radial Keratotomy or similar procedures to improve vision, eyeglasses, contact lenses, and examination for the prescription or fitting thereof;

25. any loss covered by worker's compensation, employer's liability benefits, or occupational disease law;

26. services performed by a member of Your family, services for which no charge is normally made in the absence of insurance, or services of a federal, veterans', state or municipal Hospital (unless You are financially responsible for the charges);

27. any expenses paid for under another part of the Group Policy;

28. legal expenses, whether or not incurred to obtain medical treatment;

29. any expense for which Medicare benefits are payable (benefits will not be reduced or denied because the medical expense was covered by the Medical Assistance Act of 1967, better known as Medicaid);

30. routine physical examinations for adult Insureds unless specifically provided in the Group Policy due to state mandates and described in the certificate; and

31. any item not specifically listed in the Group Policy and certificate as a benefit.

PART V - DEFINITIONS

A. "ACCIDENT/ACCIDENTAL" means any sudden or unforeseen event which results in accidental bodily Injury sustained by an Insured which is the direct cause, independent of disease or bodily infirmity or any other cause, and occurs while the Insured's coverage under the Group Policy is in force.

B. "AGGREGATE AMOUNT MAXIMUM" means the maximum amount of Eligible Expenses that will be covered under the Group Policy for each Injury or Sickness with respect to each Insured. The Aggregate Amount Maximum is shown in Schedule A.

C. "ASSOCIATION" means the Group Policyholder as shown in Schedule A.

D. "CALENDAR YEAR" means the period beginning January 1 of any year and ending December 31 of the same year.

E. "CO-INSURANCE" means the percentage of Eligible Expenses that are to be paid by You based on Your choice of Provider, after satisfaction of the Calendar Year Deductible requirements. The Co-Insurance Percentages are shown in Schedule A of the certificate unless specified otherwise in the benefit description.

F. "CO-INSURANCE MAXIMUM" means the total amount of Eligible Expenses that each Insured is required to incur each Calendar Year, after satisfaction of the Calendar Year Deductible requirements, before the Group Policy will pay one hundred percent (100%) of all additional Eligible Expenses incurred for that Insured during that Calendar Year.

The Co-Insurance Maximum amounts are shown in Schedule A of the certificate. There is an In-Network Co-Insurance Maximum amount and an Out-of-Network Co-Insurance Maximum amount. Eligible Expenses which are not subject to payment of Co-Insurance cannot be used to satisfy the Co-Insurance Maximums.

Co-Insurance Maximum amounts apply to each Insured each Calendar Year even though a condition or claim may continue from one (1) Calendar Year to the next. After three (3) Insureds within a family have met the In-Network Co-Insurance Maximum amount in a Calendar Year, additional Eligible Expenses of any Insured within the same family will not be subject to Co-Insurance for the remainder of that same Calendar Year.

G. "COMPLICATIONS OF PREGNANCY" means:

1. Hospital confinement required to treat conditions, such as the following, in a pregnant female: acute nephritis; nephrosis; cardiac decompensation; HELLP syndrome; uterine rupture; amniotic fluid embolism; chorioamnionitis; fatty liver in pregnancy; septic abortion; placenta accreta; gestational hypertension; puerperal sepsis; peripartum cardiomyopathy; cholestasis in pregnancy; thrombocytopenia in pregnancy; placenta previa; placental abruption; acute cholecystitis and pancreatitis in pregnancy; postpartum hemorrhage; septic pelvic thromboplebitis; retained placenta; venous air embolus associated with pregnancy; miscarriage; or an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of

descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section.

2. Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism; hepatitis B or C; HIV; Human papilloma virus; abnormal PAP; syphilis; Chlamydia; herpes; urinary tract infections; thromboembolism; appendicitis; hypothyroidism; pulmonary embolism; sickle cell disease; tuberculosis; migraine headaches; depression; acute myocarditis; asthma; maternal cytomegalovirus; urolithiasis; DVT prophylaxis; ovarian dermoid tumors; biliary atresia and/or cirrhosis; first trimester adnexal mass; hyditidiform mole; or ectopic pregnancy.

H. "DEDUCTIBLE" means the amount of Eligible Expenses for which no benefits are payable in any one Calendar Year. The Calendar Year Deductibles are based on Your choice of provider and are shown on the Schedule A page of the certificate. The Deductible is Your sole responsibility and must be satisfied by incurring charges which are Eligible Expenses under the terms of the Group Policy, excluding those Eligible Expenses that are not subject to the Calendar Year Deductible. Part II.A. of the Group Policy and the certificate sets forth the Deductible requirements.

If two (2) or more Insureds in the same family are injured in the same Accident, only one (1) Deductible and one (1) Co-Insurance Maximum amount will be required during that Calendar Year for all Eligible Expenses resulting from Injuries sustained in the Accident.

Certain benefits under the Group Policy may not be subject to the Calendar Year Deductibles shown in Schedule A of the certificate. These benefits may instead be subject to a separate Deductible for that particular benefit. These types of provisions are set forth in the description for the particular benefit.

I. "EFFECTIVE DATE" means the date shown in Schedule A of the certificate on which coverage begins for Insureds who were listed on the original application and for whom issuance of coverage was approved. The Effective Date of coverage for an Insured who is added at a later date will be shown on an endorsement which will be issued by the Company to provide evidence of the addition.

J. "ELIGIBLE DEPENDENT(S)" means:

1. the legal spouse of the Insured named in Schedule A of the certificate;

2. an unmarried child of either the Insured named in Schedule A of the certificate or that Insured's legal spouse, who is:

   a. less than nineteen (19) years old;

   b. less than twenty-four (24) years old and in regular full-time attendance at any college or university accredited as an institution of higher learning. "Full-time attendance" shall mean twelve (12) credit hours per semester; or

   c. medically certified as disabled and dependent upon the Insured named in Schedule A of the certificate, regardless of age.

"Spouse" includes a domestic partner or participant in a civil union if the relationship is legally recognized in Your state or jurisdiction of residence.

"Child" includes a natural child, a legally adopted child, or a child placed for adoption with the Insured named in Schedule A of the certificate on or after its Effective Date. "Child" also includes a minor grandchild, niece, or nephew who is under the primary care of the Insured named in Schedule A of the certificate, if the legal guardian of the child other than the Insured named in Schedule A of the certificate is not covered by an accident and sickness plan. "Primary care" means the provision of food, clothing, and shelter on a regular and continuous basis during the time that public school is in regular session.

K. "ELIGIBLE EXPENSES" are those benefits contained in the Group Policy and described in the certificate. Services and materials will be considered Eligible Expenses only to the extent that:

1. expenses do not exceed the Usual and Customary Charges;

2. expenses are incurred while Your coverage is in force under the Group Policy; and

3. services and materials are Medically Necessary and are furnished at the direction of or under the supervision of a Physician.

L. "HOME HEALTH CARE" means care which is provided by a public or private agency that specializes in giving nursing and other therapeutic services in Your home or place of residence. The agency must be licensed as such or, if no license is required, approved by a state department or agency having authority over Home Health Care.

M. "HOSPICE CARE" means treatment provided by a public agency or private organization which meets all of the following requirements:

1. is primarily engaged in providing care to terminally ill patients;

2. provides twenty-four (24) hour care to control the symptoms associated with terminal Sickness;

3. has on its staff an interdisciplinary team which includes at least one (1) Physician, one (1) registered nurse (RN), one (1) social worker, and at least one (1) pastoral or other counselor, and volunteers;

4. is a licensed organization whose standards of care meet those of the National Hospice Organization;

5. maintains central clinical records on all patients;

6. provides appropriate methods of dispensing drugs and medicines; and

7. offers a coordinated program of home care and inpatient care for a terminally ill patient and the patient's family.

The term "Hospice" does not include any organization or part thereof which is primarily engaged in providing custodial care, or care for drug abusers, drug addicts, alcohol abusers, or alcoholics, or domestic services, a place of rest, a place for the aged, or a hotel or similar institution.

N. "HOSPITAL" means only an institution which meets the following requirements:

1. is an institution operated pursuant to law; and

2. is primarily engaged in providing or operating - either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under supervision of a staff of one (1) or more duly licensed Physicians - medical, diagnostic and surgical

facilities for medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

3. provides twenty-four (24) hour nursing service by or under the supervision of registered nurses (RNs).

The term "Hospital" also means ambulatory surgical center, provided that any services performed therein would have been covered under the terms of the Group Policy as an eligible inpatient service.

This definition shall not include an institution, or that part of an institution, operating primarily:

1. as a convalescent home, rest, nursing, or convalescent facility; or

2. as a facility affording custodial or educational care, or a facility for the aged; or

3. as a military Hospital, veterans' Hospital, or soldiers' home or any institution contracted for or operated by the federal government or any agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered where a legal liability exists for charges made to the individual for such services.

O. "INJURY" means bodily harm caused by an Accident, directly and independently of all other causes. The Injury must occur while Your coverage is in force.

P. "INSURED" means the Association member named in Schedule A of the certificate and all covered Eligible Dependents.

Q. "INTOXICATED/INTOXICATION" means a level of blood alcohol content that is specified in the laws defining Intoxication in the state where the loss or cause of loss occurred.

R. "LIFETIME MAXIMUM" means the maximum amount of Eligible Expenses that will be covered under the Group Policy for all claims submitted by the Insured named in Schedule A of the certificate and his or her covered Eligible Dependents, after which coverage for that Insured and his or her Eligible Dependents will become null and void. The Lifetime Maximum is shown in Schedule A.

S. "MANIFESTS/MANIFESTED" means that a condition is active and that there is a distinct symptom (or symptoms) from which a Physician could diagnose the condition with reasonable accuracy or when a symptom (or symptoms) is of sufficient severity to cause a person to seek medical diagnosis or treatment.

T. "MEDICAL EMERGENCY" means the sudden onset or sudden worsening of a medical condition which is evidenced by symptoms of such severity, including severe pain, that a failure to immediately provide medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

1. placing the patient's mental or physical health in serious jeopardy;

2. serious impairment to bodily functions;

3. serious dysfunction of any bodily organ or part;

4. serious disfigurement; or

5. in the case of a pregnant woman, serious jeopardy to the health of a fetus.

U. "MEDICALLY NECESSARY" means a service or supply which is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on current generally accepted medical practice. A service or supply will not be considered as Medically Necessary if:

1. it is provided only as a convenience to You or a health care provider;

2. it is not appropriate treatment for Your diagnosis or symptoms;

3. it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or

4. it is part of a plan of treatment that is experimental, unproven or related to a research protocol, in the sense that its effectiveness is not generally recognized by the medical community.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

V. "MEDICAID" means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

W. "MEDICARE" means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

X. "MENTAL OR EMOTIONAL DISORDER" means a neurosis, psychoneurosis, psychosis, or a mental or emotional disease or disorder of any kind as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

Y. "NETWORK PROVIDER" means any Hospital, Physician or other provider of medical services that has contracted with Preferred Provider Networks to furnish such services at discounted rates to the Company's Insureds. A provider who has terminated his/her contract with the Preferred Provider Network is not a "Network Provider".

Z. "NON-NETWORK PROVIDER" means any Hospital, Physician, or other provider of medical services that does not have a contract to provide services at discounted rates to the Company's Insureds through a Preferred Provider Network.

AA. "PHYSICIAN" means a duly licensed Doctor of Medicine, Osteopath, Podiatrist, Chiropractor, Midwife, Nurse Anesthetist, Psychologist or any other health care practitioner providing a covered service and acting within the scope of his or her license who is required to be recognized by any law applicable to health insurance in the state where the service is provided. The term "Physician" does not include the Insured or an Insured's close relative - spouse, domestic partner, parent, sister, sister-in-law, brother, brother-in-law, aunt, uncle, grandparent, niece, nephew, child or cousin - or an individual residing in an Insured's household.

BB. "PRE-CERTIFICATION/PRE-CERTIFIED" means the process described in Part I of the Group Policy and the certificate whereby Our Utilization Services Division reviews a proposed non-emergency Hospital confinement, outpatient surgical procedure or emergency Hospital confinement for medical necessity and appropriateness.

CC. "PRE-EXISTING CONDITION" means the existence of symptoms which would cause a person to seek diagnosis, care or treatment within the twelve (12) month period preceding the Effective Date of coverage under the Group Policy;

OR

a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within the twelve (12) month period preceding the Effective Date of coverage under the Group Policy.

DD. "SCHEDULE A" means the schedule found on page 3.

EE. "SICKNESS" means an illness or disease which first Manifests itself after the Effective Date of Your coverage under the Group Policy and while such coverage is in force. Sickness includes congenital illnesses or defects in newborn Eligible Dependents or children placed for adoption with the Insured named in Schedule A of the certificate on or after its Effective Date.

Sickness also includes Complications of Pregnancy which occur after Your Effective Date of coverage under the Group Policy. Sickness does not include normal pregnancy.

FF. "TOTALLY DISABLED/TOTAL DISABILITY" means:

1. with respect to the Insured named in Schedule A of the certificate, or a covered spouse or domestic partner, that he or she is unable to perform, by reason of Injury or Sickness, the material and substantial duties of his or her occupation and is under the regular care and attendance of a Physician for the condition causing the Total Disability;

2. with respect to an Eligible Dependent, other than a covered spouse or domestic partner, that he or she is prevented, by reason of Injury or Sickness, from engaging in the normal and customary duties and activities of a person of like age and sex, and is under the regular care and attendance of a Physician for the condition causing the Total Disability.

GG. "USUAL AND CUSTOMARY CHARGES" means:

1. For services provided by Network Providers: the contracted rate in effect for that Network Provider on the date that the service is provided to an Insured; or

2. For services provided by a Non-Network Provider: charges for medical services or supplies which are in an amount not exceeding the normal rates charged for the same or similar services or supplies in the geographic region where the service or supply is furnished. Geographic region is a zip code, city, county, or such area as is necessary to obtain a representative cross section of medical and Hospital costs.

HH. "WE", "US", or "OUR" means the National Health Insurance Company. Also referred to as the "Company".

II. "YOU" and "YOUR" means all Insureds.

PART VI - ELIGIBILITY PROVISIONS

A. ELIGIBILITY AND EFFECTIVE DATE

1. EFFECTIVE DATE

   Persons who apply for this coverage must provide evidence of insurability satisfactory to the Company in order for the Company to issue coverage. The Effective Date is shown in Schedule A of the certificate for all applicants listed on the original application for

insurance. The Effective Date for Eligible Dependents who apply for coverage at a later date will be the first day of the month following the date on which the Company approves the Eligible Dependent's insurability, except for newborns and adoptees as provided in the following paragraphs.

2. NEWBORN CHILDREN

   If a child is born to the Insured named in Schedule A of the certificate on or after the Effective Date of the certificate, the child will be immediately covered under the Group Policy as of the moment of birth. This automatic coverage will cease at the end of ninety (90) days. To continue coverage beyond the ninety (90) day period, You must notify Us in writing at the address shown on page 1 of the certificate prior to the end of the automatic coverage, of Your desire to add the child permanently to Your coverage. Any premium due for the continued coverage must also be submitted within the ninety (90) day period. A Pre-Existing Condition exclusion period will not be applied to the newborn.

3. ADOPTED CHILDREN

   Any minor child under the charge, care and control of the Insured named in Schedule A of the certificate whom the Insured has filed a petition to adopt on or after the Effective Date of the certificate will be immediately covered under the Group Policy. Coverage will begin on the date of the filing of a petition for adoption if the Insured applies for coverage within sixty (60) days after the filing of such petition for adoption. For a newborn adoptee, coverage will begin from the moment of birth if the petition for adoption and application for coverage are filed within sixty (60) days after the child's birth. A Pre-Existing Condition exclusion period will not be applied to the adoptee. Coverage for any prospective adoptee will cease upon termination of the application for adoption.

B. TERMINATION OF INSURANCE

1. Coverage for the Insured named in Schedule A of the certificate will terminate upon the earliest of:

   a. the date on which the required premium is not paid, subject to the "Grace Period" provision in Part VIII of the Group Policy and certificate;

   b. the date on which the Insured ceases to be a member of the Association to which the Group Policy is issued;

   c. the death of the Insured;

   d. the date on which You perform an act or practice that constitutes fraud or make an intentional misrepresentation of material fact under the terms of the Group Policy; or

   e. the date on which the Group Policy or all individual health insurance coverage as defined by Public Law 104-191 is terminated in Your state in accordance with Public Law 104-191 and any applicable state law.

2. Coverage for an Eligible Dependent will cease on the earliest of:

   a. the date on which coverage for the Insured named in Schedule A of the certificate terminates as described in paragraph one of this section; or

   b. the last day of the premium month in which a dependent ceases to meet the definition of an Eligible Dependent.

If an identifiable premium is accepted after the termination date for an Eligible Dependent, coverage for that dependent will continue in force until the end of the period for which premium has been paid.

C. CONTINUATION OF COVERAGE

1. TERMINATION OF EMPLOYMENT OR MEMBERSHIP: Any Insured whose coverage under the Group Policy would otherwise terminate due to termination of employment or membership in the Association may continue coverage under the Group Policy as provided herein. To have the right to continue coverage, the Insured must have been covered under the Group Policy, or any it replaced, for at least three (3) months prior to the date coverage would terminate.

   Continuation of coverage shall not be available to an Insured who is eligible for full coverage under any other group coverage, including coverage for any Pre-Existing Conditions the Insured may have.

   An Insured who wishes to continue coverage must submit a written request for continuation to Us within ten (10) days after the termination of employment or membership.

   An Insured who requests continuation of coverage must pay the premium required on a monthly basis in advance, subject to the provisions of Part VIII.A. of the Group Policy and certificate.

   Continuation of coverage shall end upon the earliest of:

   a. one hundred twenty (120) days after continuation of coverage began;

   b. the date on which the required premium is not paid, subject to the "Grace Period" provision in Part VIII.A. of the Group Policy and certificate; or

   c. the date the Group Policy terminates.

   At the termination of the continued coverage, the Insured shall be eligible for a conversion policy, subject to the provisions of Part VI.E. "Medical Benefits Conversion Right".

2. LOSS OF ELIGIBILITY AS AN ELIGIBLE DEPENDENT: If an Eligible Dependent's coverage terminates as set forth in paragraph B.2., of this Part VI of the Group Policy and certificate, due to reaching the limiting age or a change in marital status, the Eligible Dependent may continue coverage without providing evidence of insurability by making the required premium payments for issuance of his or her own certificate and by becoming a dues paying member of the Association to which the Group Policy is issued. The Eligible Dependent must submit a written request for this continuation of coverage within thirty-one (31) days of the date on which coverage would otherwise terminate.

D. EFFECT OF MENTAL OR PHYSICAL HANDICAP ON TERMINATION

An unmarried Eligible Dependent's insurance may be kept in force past the date it would have ended due to age if:

1. prior to reaching that age, the Eligible Dependent is not able to earn a living due to mental or physical handicap; and

2. the Eligible Dependent remains dependent on the Insured named in Schedule A of the certificate for the majority of his or her support.

As evidence that the handicap still exists, written proof will be required, but not more often than once a year. The proof must be submitted in a form required by the Company. The handicap will be considered to have ceased if the required proof is not received when due. Otherwise, insurance of the Eligible Dependent will end when:

1. the handicap ceases; or

2. it would end for reasons other than the Eligible Dependent's age.

E. MEDICAL BENEFITS CONVERSION RIGHT

1. NATURE OF THE CONVERSION RIGHT: This right applies if You lose coverage under the Group Policy except as specified herein. You may convert, without providing evidence of insurability, to a Guaranteed Renewable Conversion Policy offering similar coverage. This right is subject to the terms of this section.

   The premium rate for the conversion policy will be based on Your current age under the converted certificate.

   You may not convert if benefits under the Group Policy cease because:

   a. premium contributions were not paid when due;

   b. benefits are replaced by similar group coverage within thirty-one (31) days; or

   c. termination of coverage is due to a complete withdrawal by the Company from the individual market in the state as allowed under state and federal law.

   To convert, You must submit the following within thirty-one (31) days of termination of coverage:

   a. written application; and

   b. the first premium payment.

2. PERSONS COVERED UNDER A CONVERSION POLICY: Any Insured who was covered under the certificate on the date of termination.

   At Our option, a separate conversion policy will be issued to each Eligible Dependent.

3. FORM OF THE CONVERSION POLICY: The conversion policy will be on a form that is allowed in the state in which it is issued.

   The benefit level of the conversion policy will not exceed the benefit level of the certificate at the time of termination. Benefit levels will take into account:

   a. stated dollar amounts;

   b. co-insurance percentages;

   c. established maximums; and

   d. deductibles.

4. EFFECTIVE DATE OF THE CONVERSION POLICY: The conversion policy will take effect on the day following termination of eligibility for medical benefits under the Group Policy.

5. PREMIUM MODE: The initial conversion premium must be quarterly.

F. EXTENSION OF MEDICAL BENEFITS

If You are Totally Disabled at the time insurance terminates, Your coverage will continue during such Total Disability but only for the bodily Injury or Sickness causing the disability. The maximum period for such coverage is the earlier of the following:

1. the date on which You cease to be Totally Disabled;

2. three (3) months after the date on which insurance coverage would otherwise have terminated; or

3. the date on which You acquire insurance under a replacement plan which provides similar benefits but only if the plan covers the Injury or Sickness causing the disability without limitation.

If You are Hospital confined at the time insurance terminates, coverage will continue until Your Hospital confinement ends or benefits are exhausted, whichever is earlier.

G. MEDICARE ENROLLMENT

If You become enrolled in Medicare at the same time that Your coverage under the Group Policy is in force, continued coverage will be provided only to the extent that the benefits payable by the Group Policy are not also reimbursed by Your Medicare coverage. Your premium rate will be revised for this change in coverage as of the first premium due date after We receive written notice of Your Medicare enrollment.

If in the future, Public Law 104-191 is amended to allow termination of Your coverage upon enrollment in Medicare, We will have the option to take such action.

H. CANCELLATION BY THE INSURED

You may cancel Your coverage under the Group Policy by sending Us a written request. In this event, Your certificate will terminate on the first premium due date following the date We receive Your written request in Our Home Office, and Your coverage will not remain in effect during the grace period described in Part VIII of the Group Policy and certificate. Our liability for a premium refund will be limited to any premium payment We accept or draft from Your bank account in error after the date We receive Your written request to cancel Your coverage. You may not cancel Your coverage in advance of a premium due date to receive a refund of unearned premiums, unless otherwise allowed by the laws of Your state.

PART VII - GENERAL CONTRACT PROVISIONS

A. ENTIRE CONTRACT: The Group Policy (with the application, Your enrollment form, and all attached options and amendments) is the entire contract between the Group Policyholder, You and Us. Any statement made by You, in the absence of fraud, will be considered a representation and not a warranty. After Your certificate has been in force for two (2) consecutive years, any statements, except fraudulent misstatements, made in Your application will not be used to void the certificate. Any statement which You make for the purpose of effecting insurance may not be used to void Your coverage or reduce Your benefits unless it is contained in a written statement signed by You or the primary Insured, a copy of which has been furnished to You or Your beneficiary.

No changes in the Group Policy or the certificate shall be valid unless approved by an executive officer of the Company and such approval be endorsed thereon or attached thereto. No agent has the authority to change the Group Policy or the certificate or to waive any of their provisions.

B. INDIVIDUAL CERTIFICATES: A certificate will be issued to the Insured named in Schedule A of the certificate that describes the provisions of the Group Policy and where the Group Policy may be inspected.

C. CONFORMITY WITH STATE STATUTES: Any provisions of the certificate that are in conflict with the statutes of the state which governs this coverage will be changed or deemed to conform with the minimum requirements of such laws as of the time such laws should or would have been effective as to the certificate.

D. WAIVER OF RIGHTS: If any provision of the Group Policy or the certificate is not enforced, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Group Policy or the certificate.

E. OTHER INSURANCE WITH THIS INSURER: Insurance effective at any one time on You under a like group or individual policy in this Company is limited to the one such policy elected by You, Your beneficiary, or Your estate, as the case may be. All premiums paid on all other such policies from the time the duplication of coverage existed will be returned without interest.

PART VIII - PREMIUM PROVISIONS

A. GRACE PERIOD: After payment of the first premium, a grace period of thirty-one (31) days following a premium due date will be allowed to pay subsequent premiums. During the grace period, Your certificate will remain in force unless written notice is received from You prior to the end of the grace period that the coverage is to be terminated. If You do not pay the premium prior to the expiration of the thirty-one (31) day period from the due date, the certificate will lapse due to non-payment of premium and coverage will cease at 12:00 p.m. on the thirty-first (31st) day. You will be liable for payment of the premium for the period that the coverage remains in force if benefits are paid for Eligible Expenses incurred during the grace period. Such payment will not extend coverage beyond the grace period.

B. REINSTATEMENT: If Your certificate lapses due to non-payment of premium, reinstatement of Your coverage may be considered if You notify Us of Your intention to reinstate. Upon such notice, We will furnish You an application to be completed and submitted along with premiums necessary to pay the certificate to a current status. Your premium payment and Your completed application for reinstatement must be received at Our Home Office at the address shown on page 1 within ninety (90) days after the last day for which premium payment was made. Reinstatement will not be effective unless approved by the Company. At Our option, the approved reinstatement may not include coverage during the lapsed period and premiums would not be charged for this period.

C. MISSTATEMENT OF AGE OR SEX: If Your age or sex has been misstated, there shall be an adjustment of the premium for the certificate, retroactive to Your Effective Date, so that there shall be paid to Us the premium for the coverage at the correct age and sex. The amount of the insurance coverage shall not be affected. Continuation of coverage shall be contingent upon payment of all premium in arrears. Any overpayment of premium by You will be promptly refunded.

D. PREMIUM CHANGES: Your premium rate can be changed at any time by giving thirty-one (31) days written notice to You. Written notice shall be considered effective when We address the notice to Your last known mailing address and deposit the notice, postage paid, into the care and custody of the United States Postal Service. You cannot be singled out for renewal rate increases due to claim loss experience on Your individual certificate.

PART IX - CLAIM PROVISIONS

A. NOTICE OF CLAIM: Written notice of claim must be given to Us within thirty (30) days after the occurrence or commencement of any loss covered by the Group Policy, or as soon thereafter as is reasonably possible. Notice given by You or on Your behalf to Our Home Office with information sufficient to identify You, shall be deemed notice to Us.

B. CLAIM FORMS: When notice of claim is received, You will be sent forms for filing Your claim. If these forms are not given to You at Your last known address within fifteen (15) days, You can meet Our requirements by giving Us a written statement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the "Proof of Loss" provision. Where claims are incurred by a non-insuring parent of a child covered under the Group Policy, claim forms and any other necessary information will be provided for the non-insuring parent to obtain benefits.

C. PROOF OF LOSS: You must furnish Us acceptable written proof of loss within ninety (90) days of Your claim. If it was not possible for You to give proof within the ninety (90) days, Your claim will not be denied for this reason if You send the proof as soon as You can. In any event, You must send Us the proof no later than one (1) year from the time specified, unless You are legally incapacitated.

D. TIME OF PAYMENT OF CLAIMS: Payments for a covered claim will be made to You as they are incurred, within the time frames required by law in Your state of residence.

E. PAYMENT OF CLAIMS: All payments will be made to You, unless You direct otherwise in writing or except as provided herein. Any unpaid claim at Your death may, at Our option, be paid to Your beneficiary or estate. Where covered expenses are incurred by a non-insuring parent of a child that is covered under the Group Policy, benefits will be payable, as appropriate, to the non-insuring parent, a health care provider, or a state or federal agency when required by law.

F. PHYSICAL EXAMINATIONS AND AUTOPSY: We have a right to have You examined, at Our expense, as often as reasonably necessary while a claim is pending. In case of death, We may also have an autopsy performed unless prohibited by law.

G. CLAIMS APPEAL: If Your claim is denied in whole or in part, You will be notified in writing. Within sixty (60) days of receiving this notification, You may request that any portion of the claim for which You believe benefits were wrongly denied be reconsidered. Your request for reconsideration must be in writing, and must include:

1. the name and address of the Insured named in Schedule A of the certificate and the patient;

2. the Certificate Number;

3. the date(s) of service;

4. the claim number from the decline notice;

5. the provider's name; and

6. the reason why the claim should be reconsidered.

You may, within forty-five (45) days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. Written releases may be required, if it is determined that the information is sensitive or confidential. You may also, within forty-five (45) days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

A written decision will be provided to You within sixty (60) days after Your request for review has been received. That written decision will indicate the reasons for the decision and refer to the Group Policy provision(s) on which it was based. In special circumstances, additional time may be necessary to make a decision. You will be informed if this happens but it will never be more than one hundred twenty (120) days from the date of the original declination.

After You receive Our decision and if You disagree with the decision, You may request External Review as described in the following paragraph or arbitration as described in Part X of the Group Policy and certificate.

These claims appeal procedures also apply to any Utilization Review decision which is made as described in Part I of the Group Policy and certificate.

H. RIGHT TO EXTERNAL REVIEW: Within sixty (60) days after the date of receipt of a notice of an Adverse Determination or Final Adverse Determination, You may file a request for an external review with Us.

All requests for external review must be made in writing to National Health Insurance Company at 1901 N. State Highway 360, Grand Prairie, Texas 75050 or Post Office Box 619999, Dallas, Texas 75261-6199.

A request for an external review may not be made until You have exhausted Our Claims Appeal procedure.

An external review decision is binding on both You and Us except to the extent either of Us have other remedies available under applicable federal or state law.

Except in the case of a request for an expedited external review, at the time of filing a request for external review, You must submit to the independent review organization a filing fee of twenty-five dollars ($25.00) along with the information and documentation to be used by the independent review organization in conducting the external review. Upon application by You, the commissioner may waive the filing fee upon a showing of undue financial hardship. The filing fee will be refunded to the person who paid the fee if the external review results in the reversal, in whole or in part, of Our Adverse Determination or Final Adverse Determination that was the subject of the external review. If a request for a standard external review or an expedited external review is filed against Us, We will pay the cost of the independent review organization for conducting the external review and will not charge back the cost of the external review to a health care provider.

You have the right to contact the Commissioner of Insurance for assistance at any time by phoning (800) 852-5494, e-mailing Insurance.Consumers@arkansas.gov, or writing to 1200 West Third Street, Little Rock, Arkansas 72201-1904.

When filing a request for an external review, You will be required to authorize the release of any of Your medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Notice related to an Adverse Determination: You may file a request for an expedited external review at the same time You file a request for an expedited review of an appeal as set forth in Our internal grievance procedure or utilization procedure if:

1. You have a medical condition where the timeframe for completion of an expedited review of an appeal set forth in Our internal grievance procedure or utilization review procedure would seriously jeopardize Your life or health or Your ability to regain maximum function; or

2. the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is "experimental" or

"investigational", and Your treating Physician certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

The independent review organization conducting the external review will determine whether You will be required to complete Our expedited internal grievance procedure or utilization review procedure before it conducts the expedited external review.

If You file an appeal under Our internal grievance procedure or utilization review procedure, and if We have not issued a written decision to You within thirty (30) days following the date You file the appeal with Us for a Pre-Certification claim or within sixty (60) days following the date You file the appeal with Us for a non-Pre-Certification claim, and You have not requested or agreed to the delay, You may file a request for external review and will be considered to have exhausted Our internal grievance procedure or utilization review procedure.

Notice related to a Final Adverse Determination: You may file a request for an expedited external review if:

1. You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function; or

2. if the Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which You received emergency services, but have not been discharged from the facility; or

3. a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, and Your treating Physician certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested health care service or treatment that is the subject of the requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

"Adverse Determination" means a determination by Us that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because the requested health care service does not meet Our requirements for medical necessity, or the requested health care services have been found to be "experimental/investigational".

In order to qualify as an "Adverse Determination" for purposes of external review, the decision must involve treatment, services, equipment, supplies, or drugs that would require Us to expend five hundred dollars ($500.00) or more.

"Adverse Determination" does not include a determination by Us to deny a health care service based upon:

1. an express exclusion in the health benefit plan other than a general exclusion for "medical necessity" or "experimental/investigational";

2. an express limitation in the health benefit plan with respect to the number of visits, treatments, supplies or services for a covered benefit in a given calendar period or over Your lifetime;

3. an express limitation in the health benefit plan with respect to a maximum dollar limitation with respect to a covered benefit in a given calendar period or over Your lifetime;

4. a determination by Us that You are not eligible to be a covered person;

5. a determination by Us that treatment, service, or supplies were requested or obtained by You through fraud or material misrepresentation;

6. the health benefit plan's procedure for determining Your access to a health care provider;

7. illegality of services or the means or methods of administering them;

8. FDA or other government agency determinations, reports, or statements; or

9. licensure, permit or accreditation status of a health care provider.

"Final Adverse Determination" means an Adverse Determination involving a covered benefit that has been upheld by Us at the completion of Our internal grievance procedure or utilization review procedure.

PART X - ARBITRATION OF CLAIM DISPUTES

Any dispute regarding claims processing or administration that has not been resolved after the procedures described in the "Claims Appeal" section of Part IX of the Group Policy and certificate have been followed, shall be resolved through non-binding arbitration. Such arbitration shall be administered under the rules of the American Arbitration Association (AAA). One (1) arbitrator shall decide the dispute, unless all parties agree to have three (3) arbitrators. Unless otherwise agreed by all parties, any arbitrator must be a licensed attorney who has practiced life, health and accident insurance law for at least five (5) years. Unless otherwise agreed by all parties, the arbitrator(s) shall be appointed from a list of qualified persons provided by AAA. Any court having proper jurisdiction over all parties may render judgment based upon the award of the arbitrator(s). All fees and expenses of the arbitration shall be paid by the parties equally, except that each party shall pay the cost of its own attorney, experts, witnesses and the preparation and presentation of its proof. The Federal Arbitration Act shall govern the arbitration. Such arbitration shall be a condition precedent to legal action by the Insured or the Company.

All aspects of the arbitration are confidential. Neither a party, an attorney for a party nor an arbitrator may disclose the evidence, content or results of the arbitration without the prior written consent of all parties.

PART XI - APPEAL AND ARBITRATION OF OTHER DISPUTES

Complaints and disputes other than those involving claims processing or administration will first be handled under the same general procedures as those set forth under Part IX of the Group Policy and certificate regarding "Claims Appeal". If this process does not resolve the complaint or dispute, then the matter will be resolved by non-binding arbitration under the same terms as provided under Part X of the Group Policy and certificate regarding "Arbitration of Claim Disputes".

PART XII - COORDINATION OF BENEFITS (COB)

A. COORDINATION OF BENEFITS: You may have other medical expense coverage in addition to this coverage. If so, the benefits from the "Other Plan" will be considered when Your claim is paid. This may require a reduction of benefits under this coverage so that the combined benefits will not be more than one hundred percent (100%) of Your "Allowable Expenses".

B. ORDER OF COORDINATION: To determine whether Our benefits will be reduced, the order in which the various plans will pay benefits has to be determined. This will be done as follows:

1. a plan with no provision to coordinate with other plans will be considered to pay its benefits before a plan which has such a provision;

2. a motor vehicle accident policy will be considered to pay its benefits before other plans for expenses incurred as a result of a motor vehicle accident;

3. a plan which covers You other than as a dependent will be considered to pay its benefits before a plan which covers You as a dependent;

4. a plan which covers You as a dependent of a person whose birthday occurs earlier in the year will be considered to pay its benefits before a plan which covers You as a dependent of a person whose birthday occurs later in the year; except in the case of separation or divorce, the following rules will apply:

    a. the plan of the parent with custody, who is not remarried, will be considered before the parent without custody;

    b. if the parent is remarried, and has custody of the child, the plan of the step-parent will be considered before the plan of the parent without custody;

    c. if there is a court decree which established financial responsibility for medical or health care expenses with respect to dependent children, the benefits of the plan of the parent with financial responsibility shall be considered before the benefits of any other plan;

5. the primary plan of a retired or laid-off employee who is covered by two (2) employers will be the plan which covers him/her as an active full-time employee; and

6. if 1, 2, 3, 4, or 5 above do not establish the order of payment, the plan under which You have been covered the longest will pay its benefits first. The date You first became a covered member of the group will be used as the oldest date of coverage.

C. OTHER PLAN: "Other Plan" means any other plan of medical expense coverage provided by:

1. group or blanket insurance coverage;

2. group Blue Cross, Blue Shield, other group prepayment coverage or health maintenance organization;

3. coverage under an employer sponsored self-insurance plan;

4. a motor vehicle insurance policy; and

5. coverage provided under any governmental program or required or provided by any statutes, except Medicaid or Medicare.

The term "Other Plan" will not include individual insurance or subscriber contracts, or group or blanket school accident type coverages, or hospital indemnity benefits.

D. ALLOWABLE EXPENSE: "Allowable Expense" means any usual or customary medical expense which is covered under any of the plans involved. An allowable charge to a "Secondary" plan includes the value or amount of any deductible, co-insurance percentage, or amount of

otherwise allowable expenses which were not paid by the "Primary" or first paying plan. Coordination of Benefits will not apply to claims of less than one hundred dollars ($100.00).

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION: Certain facts are needed to apply these COB rules. We may get material facts from each person claiming benefits and also gather material facts from or give them to any other insurance company or health benefit plan administrator with whom We coordinate benefits.

F. FACILITY OF PAYMENT: A payment made under another plan may include an amount which should have been paid under this plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again.

G. RIGHT TO RECOVERY: If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;

2. insurance companies; or

3. other organizations.

H. RIGHT OF SUBROGATION OR REIMBURSEMENT: Upon Our payment of any benefits under this coverage, We shall be subrogated to all of Your rights of recovery against any person or legal entity that may be liable to You, whether in contract or tort, for a claim arising out of or related to Your Injury or Sickness, but only to the extent of the benefits so provided. You shall cooperate with Us and do whatever is necessary for Us to secure Our subrogation rights and to collect Our subrogation claim. You shall not settle any such claim without Our consent or do anything to prejudice Our subrogation rights or Our efforts to collect Our subrogation claim.

As security for Your obligations to Us, You grant Us a lien on any sum of money that You may recover by settlement, judgment or otherwise, from any person or legal entity for a claim arising out of or related to Your Injury or Sickness. You agree that out of any such recovery, We shall receive the first disbursement for the amount of the benefits that We paid, regardless of whether You have been fully compensated and before payment of any other existing claims, including any claim by You for general damages. If any applicable law does not allow subrogation, You agree to reimburse Us from any such recovery for any benefits that We paid under this coverage, before applying the recovery to any other existing claim.

In the event You recover from the third party, reasonable cost of collection and attorney's fees thereof shall be assessed against You and Us in the proportion each benefits from the recovery.

RIDER

Attached to and forming a part of Policy/Certificate No. _____ and all attached endorsements and/or supplements,

issued by

NATIONAL HEALTH INSURANCE COMPANY,

herein called the "Company",

Your Policy/Certificate (hereafter called the "Base Plan") is amended as follows:

OUTPATIENT PHYSICIAN VISIT BENEFIT RIDER

DESCRIPTION OF PHYSICIAN VISIT BENEFIT: The Company has made arrangements to access Preferred Provider Networks which include Participating Physicians (hereafter called "Network Physicians"). These Network Physicians have agreed to provide medical services at a discounted rate for the Company's Insureds.

If You incur expenses due to Injury or Sickness for a Covered Office Procedure, as defined herein, You will be responsible for a co-payment in the amount of [thirty dollars ($30.00)] per office visit to a Network Physician other than a Specialist. The co-payment amount for a visit to a Network Physician who is a Specialist is [sixty dollars ($60.00)] per office visit.

If You incur expenses due to Injury or Sickness for a Covered Office Procedure, as defined herein, You will be responsible for a co-payment in the amount of [sixty dollars ($60.00)] per office visit to a Non-Network Physician other than a Specialist. The co-payment amount for a visit to a Non-Network Physician who is a Specialist is [one hundred dollars ($100.00)] per office visit.

The Covered Office Procedure must be performed by a Physician in his or her office. After Your co-payment amount, the Company will pay the remainder of the Physician's Usual and Customary Charges, with the exception of any non-covered services.

You will be financially responsible for any medical service not specifically covered by this Rider.

DEFINITION OF COVERED OFFICE PROCEDURE: A Covered Office Procedure is medical diagnosis and/or treatment of Injury or Sickness – not requiring Hospital confinement – which is routinely classified within the following Physician's Current Procedural Terminology ("CPT") code ranges:

- Office visit evaluation/management/New Patient (99201-99205) – Office or outpatient visits for the evaluation and management of a new patient.
- Office visit evaluation/management/Established Patient (99211-99215) – Office or outpatient visits for the evaluation and management of an established patient.
- Office consultation/New or Established Patient (99241 through 99245) – For a new or established patient.

Only those procedures designated by the herein listed "CPT" codes in the 2009 edition of the above referenced publication, or as subsequently renamed or renumbered, are Covered Office Procedures for purposes of this Rider.

NON-COVERED CHARGES: Charges for routine physical examinations for adults, well child visits, specialized treatment, specialized services, pathology, radiology, prescription drugs and any other services not specifically within the "CPT" code ranges herein listed are INELIGIBLE for benefits under this Rider. Physician charges for surgical services are covered under the Base Plan and are not covered under this Rider.

No benefit is payable under this Rider, unless both the Base Plan and this Rider are in force for the patient at the time the medical services are received or rendered.

The Company reserves the right, at the Company's expense, to submit any Physician's course of treatment for utilization review by a separate entity of the Company's choice. Any treatment not found to be Medically Necessary or appropriate for the condition being treated will not be considered a Covered Office Procedure.

NONDUPLICATION OF BENEFITS: If the Base Plan or any other endorsement or rider to the Base Plan also provides benefits for a Covered Office Procedure, then that Covered Office Procedure will be processed and the benefit will be paid under only ONE of the following: (1) the Base Plan; (2) this Rider; or (3) any other endorsement or rider - whichever provides the greatest benefit. Benefits payable under this Rider will not duplicate any other benefits payable under the Base Plan or any attached endorsements or riders.

BASE PLAN DEDUCTIBLE, CO-INSURANCE AND MAXIMUMS: Charges incurred for which benefits are payable under this Rider will not be applied toward the satisfaction of the Deductible(s) or any Co-insurance amount(s) due under the Base Plan or any other endorsement or rider attached to the Base Plan.

Benefits payable under this Rider are subject to the Aggregate and Lifetime Maximum Amounts set forth under the Base Plan.

PRESERVATION OF BASE PLAN LIMITATIONS AND EXCLUSIONS: Claims made under this Rider are not subject to the Base Plan's Pre-Existing Condition limitation. However, payment of benefits under this Rider does NOT constitute an agreement or admission that the Injury or Sickness for which medical care was received is a covered Injury or a covered Sickness, as defined in the Base Plan.

Processing claims and paying benefits under this Rider does **NOT** constitute notice to the Company of any physical condition that has been or will be treated.

With respect to any claims made under the Base Plan, neither the receipt of a claim nor the payment of benefits under this Rider shall constitute a waiver of the Company's right to enforce any limitations or exclusions contained in the Base Plan, including, but not limited to, (1) the waiting period for Pre-Existing Conditions; (2) conditions subject to probationary or waiting periods before coverage becomes effective; (3) specific exclusions and causes of loss; and (4) any other applicable limitations and exclusions.

CO-PAYMENT CHANGES: The co-payment amounts, for which You are financially responsible, may be changed by the Company at any time upon mailing thirty (30) days written notice (sixty (60) days in Arizona) to Your last known address. The co-payment amounts can be changed only if the same change is made to all plans of the same class in Your state.

TERMINATION OF BENEFIT: The Company reserves the right to terminate benefits under this Rider at any time, upon mailing thirty (30) days written notice (sixty (60) days in Louisiana by certified mail) to Your last known address. This benefit may be terminated only if all plans of the same class in Your state are also affected. Premium amounts payable for Your coverage will be adjusted accordingly if applicable.

In addition to the definitions contained in the Base Plan, the following definitions shall apply to this Rider:

"NETWORK PHYSICIAN" means a Physician that has contracted with Preferred Provider Networks to furnish medical services at discounted rates to the Company's Insureds. A Physician who has terminated his/her contract with the Preferred Provider Network is not a "Network Physician".

"NON-NETWORK PHYSICIAN" means a Physician that has not contracted with Preferred Provider Networks to furnish medical services at discounted rates to the Company's Insureds.

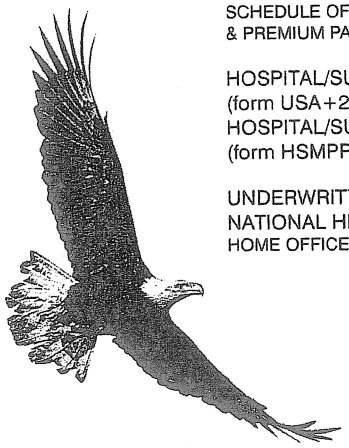
"SPECIALIST" means a Physician who has received additional education and training in a specified area or branch of medicine or surgery and who is certified by the appropriate medical board responsible for certification of the specific practice area. For purposes of this Rider, "Specialist" will not include a Physician whose area of specialty is internal medicine, pediatrics, obstetrics or gynecology.

"USUAL AND CUSTOMARY CHARGES" for purposes of this Rider, for services provided by a Network Physician only, means the contractual rate in effect for that Network Physician on the date that the service is provided to an Insured. For services provided by a Non-Network Physician, the existing definition in the Base Plan applies.

In Witness Whereof, NATIONAL HEALTH INSURANCE COMPANY has issued this Rider at its Administrative Office in Grand Prairie, Texas this _____ day of_____,_____, which is the effective date hereof:

Secretary

President



APPLICATION FOR INSURANCE

SCHEDULE OF COVERAGE SELECTED
& PREMIUM PAID

HOSPITAL/SURGICAL/MEDICAL
(form USA+2002)
HOSPITAL/SURGICAL/MEDICAL PPO
(form HSMPPO-2009)

UNDERWRITTEN AND ADMINISTERED BY:
NATIONAL HEALTH INSURANCE COMPANY
HOME OFFICE —GRAND PRAIRIE, TEXAS

REQUESTED EFFECTIVE DATE: _____

ELECTRONIC APPLICATION: O Yes O No

HOME OFFICE USE ONLY

I.D. NO. _____

BASE PLAN DEDUCTIBLE: O $ 2,000 O $ 4,000 O $ 5,000 O $10,000 O $15,000 O $25,000

BENEFIT (CO-INSURANCE) PERCENTAGE OPTION : O 80/20% O 70/30% O 60/40% O 50/50%

OUTPATIENT MEDICAL BENEFIT DEDUCTIBLE: O $1,000 O $1,500 O $2,000 O $2,500 O $5,000 O $10,000

PPO: O Yes O No NETWORK _____

TOBACCO USER-APPLICANT: O Yes O No

TOBACCO USER-SPOUSE: O Yes O No

PAYMENT MODE: O Monthly O Quarterly O Semi-Annual O Annual

PAYMENT TYPE: O BANK-DRAFT O DIRECT O LIST BILL

References to "Spouse" in this Application include a domestic partner or a participant in a civil union if legally recognized in your state or jurisdiction of residence.

PRINT APPLICANTS' NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	Relation to APPL.	DATE OF BIRTH	AGE	P/S	FTS Y/N	BIRTH STATE	HEIGHT	WEIGHT	PREMIUM
1.			Appl.								
2.											
3.											
4.											
5.											

RESIDENT ADDRESS (Actual address. We cannot use a P.O. Box)	CITY	STATE	ZIP	COUNTY
MAILING ADDRESS (If different than Resident Address)	CITY	STATE	ZIP	COUNTY

BUSINESS NAME AND ADDRESS	CITY	STATE	ZIP

HOME PHONE	BUSINESS PHONE	EMAIL

DESCRIBE THE OCCUPATION AND SPECIFIC DUTIES FOR EACH ADULT APPLICANT:

APPLICANT: _____

SPOUSE: _____

TOTAL PREMIUM FOR BASE HOSPITAL/EOMB/SURGICAL PLAN (TOTALS FROM ABOVE) $ _____

INITIAL SET-UP FEE, FIRST MONTH'S ASSOCIATION DUES AND A MONTHLY ADMINISTRATION FEE $ _____

TOTAL INITIAL PAYMENT (INCLUDES PREMIUM, FEES, AND ASSOCIATION DUES) $ _____

TOTAL DUE EACH PAYMENT THEREAFTER (FUTURE PAYMENTS INCLUDE MONTHLY DUES AND A MONTHLY ADMINISTRATION FEE) $ _____

APPLICATION DATE	PRINT AGENT'S NAME (LAST, FIRST, MI)	AGENT'S NUMBER	PREMIUM	ASSOCIATION DUES	MONTHLY ADMIN. FEE

Statement Of Eligibility and Other Insurance

Applicant #1 must answer each question on behalf of each Applicant (any person to be covered). Please explain any "Yes" answer to questions 2-15 in the box at the bottom of the page

	YES	NO
1. Are all adult Applicants citizens of the United States? If "No", complete a Foreign Resident Questionnaire for each non-citizen-adult Applicant	○	○
2. Does any Applicant have any type of medical coverage now or within the past 90 days? Coverage includes but not limited to Individual, HMO, Employer-Group.	○	○
3. Will the coverage being applied for replace or change any coverage from another company?	○	○
4. Have you ever applied for coverage with National Health Ins. Co.? If issued, provide ID#	○	○
5. During the past 10 years, has any Applicant been declined medical, life or disability coverage or had such coverage rescinded? (MO residents need not answer this question.)	○	○
6. Does any Applicant participate in any hazardous sports or activities?	○	○
7. Has any Applicant ever been convicted of a felony or is anyone currently on probation?	○	○
8. Has any Applicant ever tested positive for HIV (Human Immunodeficiency Virus)? NOTE: (Residents of WI are not required to answer this question.)	○	○
9. In the past five (5) years has any Applicant been arrested for a DUI or DWI?	○	○
10. Has any Applicant ever tested positive or been diagnosed with or treated as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	○	○
11. Is any Applicant or household member-whether applying for coverage or not-currently pregnant or in the process of adopting a child? (If yes, please do not submit the Application)	○	○
During the past two (2) years has any Applicant:		
12. Used tobacco in any form including cigarettes, cigars, pipe or chewing tobacco?	○	○
13. Received disability income benefits, Worker's Compensation benefits, Social Security, or federal or state government aid such as Medicaid or Medicare, been bedridden or disabled, confined to or required the use of a wheelchair, walker, brace or crutch?	○	○
14. Received a prescription for or taken any prescribed medications? Name and reason?	○	○
15. Experienced more than a 20 pound unintentional weight loss, chronic or recurrent diarrhea, enlarged lymph glands and/or night sweats?	○	○

PLEASE PROVIDE DETAILS BELOW TO ANY "YES" RESPONSES TO QUESTIONS 2-15 ABOVE

Question #	Applicant #	Date	Explanation

Any question regarding diagnosis or treatment of a condition refers to diagnosis or treatment by a doctor or other health care professional.

Applicant #1 must answer each question on behalf of each Applicant (meaning any person to be covered). Answer either "Yes" or "No" to each part. If "Yes", please provide details for each "Yes" answer in the space provided at the bottom of the page.

16. HAS ANY APPLICANT EVER HAD SYMPTOMS OF, BEEN DIAGNOSED WITH, OR RECEIVED TREATMENT FOR:

	YES	NO
(a) Chest pain, heart murmur, mitral valve prolapse, hypertension, high blood pressure, cholesterol, heart attack, stroke, angioplasty/bypass, stent placement or any other disease or disorder of the heart or circulatory system?	O	O
(b) Anemia, lymphoma, leukemia, connective tissue disease, phlebitis, embolism or any other disease or disorder of the blood, spleen or immune system?	O	O
(c) Asthma, bronchitis, pneumonia, allergies, chronic obstructive pulmonary disease, emphysema, sleep apnea or any other disease or disorder of the respiratory system?	O	O
(d) Ulcer or stomach disorder, colitis, diverticulitis, reflux, ileitis, rectal disorder, hemorrhoids, hernia, or any other disease or disorder of the gastrointestinal system?	O	O
(e) Pancreatitis, gall stones, hepatitis, cirrhosis, or any other disease or disorder of the biliary system or liver?	O	O
(f) Prostatitis, elevated PSA, kidney stones, kidney or bladder disease, nephritis, blood or sugar in the urine or any other disease or disorder of the urinary tract or male reproductive system?	O	O
(g) Breast disorder, lump or breast-implants, endometriosis, pelvic pain, abnormal pap, infertility, a Cesarean Section delivery, Pelvic Inflammatory Disease, or any other disease or disorder of the female reproductive organs?	O	O
(h) Epilepsy or seizures, convulsions, headaches, fainting, dizziness, brain disorder, spinal cord disorder, nervous disorder, paralysis, developmental delay, autism or any other disease or disorder of the nervous system?	O	O
(i) Arthritis in any form, rheumatism, gout, fibromyalgia, osteoporosis, or any other disease or disorder of the bones, joints, muscles, spine (including scoliosis), or back, hip or knees?	O	O
(j) Polyp, cyst, cancer, tumor, dysplasia or abnormal growth whether benign or malignant?	O	O
(k) Herpes, syphilis, and/or any other sexually transmitted disease or disorder?	O	O
(l) Cataract, glaucoma, or any other disease or disorder of the eyes or ears-including tubes, nose, throat or skin?	O	O
(m) Goiter, thyroid, pituitary or adrenal gland, diabetes, abnormal blood sugar or any other disease or disorder of the endocrine system?	O	O
(n) Mental, nervous or emotional disorder; anxiety or depression, alcohol use, dependency or addiction; drug or chemical use, dependency or addiction; eating disorders?	O	O

17. In the last five (5) years, has any Applicant had any medical or surgical advice, treatment or operations other than as indicated above or been advised to have medical tests or surgery that has not yet been performed, or is awaiting medical test results? ..... O YES O NO

IF ANY ANSWER TO ANY PART OF QUESTION 16 OR TO QUESTION 17 IS "YES" FOR ANY PERSON TO BE INSURED, PROVIDE DETAILS BELOW:

Applicant #	Nature of Illness or Accident Include Diagnosis, Operations & Medications	Date Started	Date Ended	Surgery?	Hospitalized From/To	Physician's Name, Address & Phone #

18. FAMILY DOCTOR OR DOCTOR OF EACH APPLICANT WHO HAS CURRENT AND COMPLETE MEDICAL RECORDS.
(Attach extra page if more space is needed)

APPLICANT #1'S DOCTOR NAME:		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
SPOUSE'S DOCTOR NAME:		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
CHILDREN'S DOCTOR NAME:		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP

The following statements must be reviewed carefully and signed as indicated:

"I understand that no benefits are payable for a Pre-Existing Sickness or Injury until the Insured has been covered for twenty-four (24) months under the Group Policy. Variations in this Pre-Existing Condition provision due to specific state mandates will be explained by a separate Disclosure Notice* and any exclusionary riders will be explained at the time coverage is issued.
I understand the waiting period for Pre-Existing Conditions."

*Applies to SC, TX, and other states.

SIGNATURE OF APPLICANT #1 (FOR AND ON BEHALF OF ALL APPLICANTS):

X_____

"I hereby apply to National Health Insurance Company for coverage under a Certificate to be issued in reliance upon the written answers to the questions in this Application which I have answered to the best of my knowledge and belief. I understand and agree that (1) the coverage shall not take effect unless the Application has been accepted and approved in writing by the Company and until the Effective Date of my coverage under the Certificate and (2) my coverage will not become effective until all necessary underwriting information has been received and reviewed by the Home Office and that the requested Effective Date may be delayed if the Home Office requires additional medical information to process my Application and (3) the agent does not have the authority to waive a complete answer to any question in the Application, pass on insurability, make or alter any part of the contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this Application may bar the right to recover under the Group Policy if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this Application and all of the information contained herein. I acknowledge receipt/review of the Medical Information Bureau Pre-notice, Summary of Coverage, and Disclosure Notice."

DATED AT: CITY	STATE	MONTH	DAY	YEAR

SIGNATURE OF APPLICANT #1 (FOR AND ON BEHALF OF ALL APPLICANTS)	SIGNATURE OF SPOUSE, PARENT (If MINOR), NEXT OF KIN OR LEGAL REPRESENTATIVE
X_____	X_____

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and which may subject such person to criminal and/or civil penalties.

District of Columbia - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

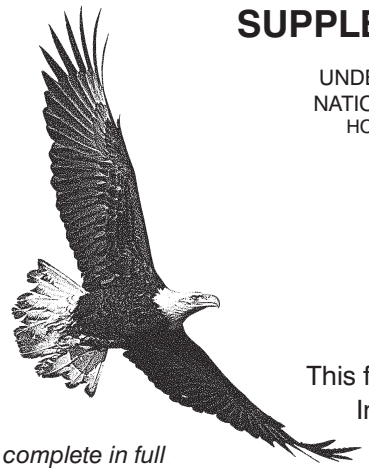
AGENT USE ONLY

1. Will this coverage applied for replace or effect a change of any coverage with this or any other company? ..... O Yes O No
2. Did you personally meet with each Applicant? (If No explain) _____ O Yes O No
3. I have truly and accurately recorded the information as herein supplied by the Applicant #1 for all the family members..... O Yes O No
4. I have left or made available a Summary of Coverage and a Disclosure Notice. ..... O Yes O No
5. Was the application solicited by: ..... O Paper O Electronic
6. Mail certificate to: ..... O Agent O Insured

AGENT NAME (PLEASE PRINT FIRST AND LAST NAME)	ADDRESS	CITY	STATE	ZIP

SIGNATURE OF AGENT	AGENT NUMBER	MONTH	DAY	YEAR
X_____				

SPLIT AGENT LAST NAME	SPLIT AGENT NUMBER	SPLIT AGENT %
1.		
2.		
3.		



SUPPLEMENT TO APPLICATION

UNDERWRITTEN AND ADMINISTERED BY:
NATIONAL HEALTH INSURANCE COMPANY
HOME OFFICE —GRAND PRAIRIE, TEXAS

This form is used to provide additional details for questions on the Application for Insurance for all applicants. Signatures obtained on the main application and the date signed are required at the bottom of this form.

Print all entries and complete in full

ADDITIONAL INFORMATION TO APPLICATION QUESTIONS

Question #	Applicant#	Dates	Treatment, Advice Given, Results and Other Details	Name and address of Doctors and Hospitals

This form must be signed where indicated below if any information is written on this form.

By my signature below, I affirm that to the best of my knowledge and belief the additional information supplied herein is correct and complete. I further understand that my Policy/Certificate, if issued, will contain a copy of this application supplement.

X _____ **X** _____

SIGNATURE OF APPLICANT #1 (FOR AND ON BEHALF OF ALL APPLICANTS) **SPOUSE* (IF TO BE COVERED) OR PARENT/GUARDIAN (IF YOU ARE A MINOR)**

X _____ **X** _____

AGENT SIGNATURE **DATE**

** Spouse includes a domestic partner or a participant in a civil union if legally recognized in your state or jurisdiction of residence.*

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/02/2009

Comments:

1) Required Arkansas Flesch Certification pursuant to ACA 23-80-206 for form filing HSMPPO-2009P
2) Required Arkansas Compliance Certification for form filing HSMPPO-2009P
3) Pursuant to Rule & Regulation 49 - The Arkansas Life, and Health Insurance Guaranty Association Act Notice. This Notice is sent with the Insurance Certificate.

Please note regarding the Consumer Information Notice required by ACA 23-79-138 and Bulletin 11-88, this prints on Page 5 of the Certificate.

Attachments:

AR-Flesch-Cert-HSMPPO2009P.pdf
AR Certification of Compliance.pdf
Arkansas Life and Hlth Guaranty Assoc Notice.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	10/02/2009
Bypass Reason:	Application forms are included in the Forms tab.		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter HSMPPO-2009P	Approved-Closed	10/02/2009

Comments:

Revised Cover Letter for form filing HSMPPO-2009P with attachment regarding group policyholder information.

Attachment:

CoverLtr2-HSMPPO-2009P-AR.pdf

		Item Status:	Status Date:

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Satisfied - Item: Copy of Original Cover Letter USA+2002P — Approved-Closed — 10/02/2009

Comments:

Copy of Original Approval Letter for Form Filing USA+2002P

Attachment:

Original Cover Ltr USA+2002P_Approval.pdf

SUBMISSION FORM FOR ARKANSAS

CERTIFICATION

This is to certify that the attached policy forms have achieved Flesch Reading Ease Scores as stated below and comply with the requirements of Ark. Stat. Ann §§ 23-80-206 through 23-80-207, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Numbers:	HSMPPO-2009P - Group Hospital Surgical Medical PPO Policy	59.20
	HSMPPO-2009 - Group Hospital Surgical Medical PPO Certificate	59.20
	RDR.POV-7/09 - Outpatient Physician Visit Benefit Rider	50.22

E A. Green
Name

Eva A. Green
Vice President / Compliance Dept.
Title of Officer of Company

8/27/09
Date

AR-FF2

State of Arkansas

C E R T I F I C A T I O N

National Health Insurance Company

Policy Forms: **HSMPPO-2009P - Group Hospital Surgical Medical PPO Policy**
HSMPPO-2009 - Group Hospital Surgical Medical PPO Certificate
RDR.POV-7/09 - Outpatient Physician Visit Benefit Rider
NH-1175-8/09 - Individual Application
NH-1161-8/09 - Supplement to Application

I have reviewed or supervised the review of the policy forms contained in this filing and hereby certify that they are in compliance with the applicable statutes, regulations, and bulletins of the State of Arkansas.

8/26/09
Date

Signature

Eva A. Green
Vice President / Compliance Department
Name and Title of Officer

AR FF4

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contractholder for unallocated annuity benefits, irrespective of the number of contracts held by the contractholder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

NATIONAL HEALTH INSURANCE COMPANY

August 28, 2009

ELECTRONIC FILING

Honorable Jay Bradford
Commissioner of Insurance
Insurance Division
1200 West Third Street
Little Rock, AR 72201-1904

RE: **National Health Insurance Company**
NAIC#: 4669-82538

Policy Form No.:	HSMPPO-2009P - Group Hospital Surgical Medical PPO Policy
Certificate Form No.:	HSMPPO-2009 - Group Hospital Surgical Medical PPO Certificate
Rider Form No.:	RDR.POV-709 - Outpatient Physician Visit Benefit Rider
Application Form No.:	NH-1175-8/09 - Individual Application *(replaces NH-1175.1/2)*
Application Form No.:	NH-1161-8/09 - Supplement to Application *(replaces NH-1161-7/1)*

Dear Commissioner Bradford:

Enclosed for your review and approval are the above referenced forms. These are new forms and are not intended to replace existing forms except as noted above. Policy form HSMPPO-2009P is a group hospital surgical medical PPO plan which will be issued to association groups in the District of Columbia. Initial group policyholder information is attached. Coverage under the group policy is evidenced by the Certificate of Insurance, HSMPPO-2009, to be issued to association members. The policy and certificate are identical with the exception of the first three pages.

This new group policy form is substantially similar to previously filed group policy form USA+2002P except that modifications have been made to create a PPO plan instead of an Indemnity product (proof of prior filing is enclosed). Rider form RDR.POV-709 will add a benefit to all certificates issued under the group policy in order to provide coverage for physician office visits.

This product will be solicited by licensed agents, using application forms, NH-1175-8/09 and NH-1161-8/09, which will be used in both paper and electronic formats. Additionally, both these applications are intended to also be used with our existing group policy form USA+2002P (proof of prior approval enclosed).

This product will not be mass marketed. This product will not be marketed to "Small Employers" as that term is defined in your state or under federal law. We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

Thank you in advance for your time spent in the review of this filing. Please contact me if you should require any additional information.

Sincerely,

Eva A. Green, AIRC, FLMI, HIA
Vice President/Compliance Dept.
(817) 640-3410
(817) 640-3465 fax
eva.green@nhic.com

GROUP POLICYHOLDER INFORMATION
GROUP POLICY FORM HSMPPO-2009P

The Small Business Association of America (SBA) was originally incorporated under the District of Columbia Nonprofit Corporation Act on June 1, 1965 and the Articles of Incorporation were amended to the current organization name as of March 15, 1991.

United Service Association For Health Care (USAHC) was originally incorporated under the District of Columbia Nonprofit Corporation Act on April 13, 1983 and the Articles of Incorporation were amended to the current organization name as of February 12, 1988. USAHC has offices in both the District of Columbia and Texas.

NATIONAL HEALTH INSURANCE COMPANY

November 30, 2001

OVERNIGHT MAIL

Honorable Mike Pickens
Commissioner of Insurance
Insurance Division
1200 West Third Street
Little Rock, AR 72201-1904

RECEIVED
DEC - 3 2001
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

ATTN: John Shields
Director, Life & Health

RE: **National Health Insurance Company**
NAIC#: 1315-82538
Policy Form No.: USA+2002P - Group Hospital Surgical Policy
Certificate Form No.: USA+2002 - Group Hospital Surgical Certificate
Rider Form No.: NH-IVMBR-2002(AR) - Optional In Vitro Fertilization Maternity Benefit Rider
Rider Form No.: NH-DBR-2002 - Optional Dental Benefits Rider
Rider Form No.: NH-PDR-2002 - Optional Prescription Drug Benefit Rider
Application Form No.: NH-1175-1/2
Supplement to Application Form No.: NH-1161-7/1

APPROVED
DEC 10 2001
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

Dear Mr. Shields:

Enclosed for your review and approval are the above referenced forms. These are new forms and are not intended to replace any existing forms.

Policy form USA+2002P is a group hospital surgical plan which is issued to the United Service Association For Health Care, sitused in the District of Columbia. Coverage under the group policy is evidenced by the Certificate of Insurance, USA+2002, to be issued to members of the Association. This product will be solicited by licensed agents using application forms, NH-1175-1/2 and NH-1161-7/1. This product will not be mass marketed. This product will not be marketed to "Small Employers" as that term is defined in your state or under federal law.

The Optional Dental, Maternity, and Prescription Drug Benefit Riders are optional benefit riders that may be selected by the applicant. Additionally, please note that application form number NH-1175-1/2 is also an application for group term life insurance coverage under group policy form NH-LTL-P01 which has been previously approved by your office (proof of approval is enclosed for your reference).

Additionally, enclosed is a rejection form signed by the group policyholder which applies to various Arkansas mandated offers of coverage.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions. Following are the Flesch scores for the submitted forms:

Policy/Certificate Form USA+2002	50.64
NH-IVMBR-2002(AR) - Optional In Vitro Fertilization Maternity Benefit Rider	52.41
NH-DBR-2002 - Optional Dental Benefits Rider	53.50
NH-PDR-2002 - Optional Prescription Drug Benefit Rider	45.95

Your early review of this submission will be greatly appreciated. If I can provide any additional information, please contact me at our toll-free number 1-800-237-1900, extension 3748.

Sincerely,

Banu Loyd

REC'D S & C DEPT.
DEC 11 2001

Ms. Banu Loyd
Contract and Compliance Analyst
banu.loyd@nhic.com

SERFF Tracking Number:	*NHIC-126264594*	*State:*	*Arkansas*
Filing Company:	*National Health Insurance Company*	*State Tracking Number:*	*43356*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*HSMPPO-2009P-AR*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/12/2009	Form	Group Hospital Surgical Medical PPO Policy	10/01/2009	HSMPPO-2009-GrpPol-AR-082609.pdf (Superceded)
08/12/2009	Form	Group Hospital Surgical Medical PPO Certificate	10/01/2009	HSMPPO-2009-Cert-AR-082609.pdf (Superceded)
08/27/2009	Supporting Document	Cover Letter HSMPPO-2009P	09/30/2009	AR-Cover Ltr-HSMPPO2009P.pdf (Superceded)

GROUP HOSPITAL/SURGICAL/MEDICAL INSURANCE POLICY
NATIONAL HEALTH INSURANCE COMPANY

P. O. Box 619999
Dallas, TX 75261-6199
1-800-237-1900

(Referred to in this Policy as the Company, We, Us, Our)

Group Policyholder [ABC Association]

Effective Date [07/01/09]

Group Policy Number [HSMP-ABC]

State of Delivery DC

Premiums due on [1st]

First Renewal Date [08/01/09]

OUR INSURING AGREEMENT: We will pay benefits for certain expenses an Insured incurs, as explained in the Policy, while the Group Policy is in full force as to that person.

We, National Health Insurance Company, issue this Group Policy in consideration of the application and the payment of premiums. Our Company and the Group Policyholder are bound by the conditions and provisions of this Group Policy.

EFFECTIVE DATE: This Group Policy becomes effective at 12:01 A.M. on the Effective Date and in the state specified above. The Group Policy will continue in force by the payment of premiums when due.

ENTIRE POLICY: The following pages, including any riders, endorsements or amendments, along with the application for insurance, constitutes the complete agreement between the Group Policyholder and Us.

Signed at Our Home Office, Grand Prairie, Texas.

Secretary President

GROUP INSURANCE POLICY
NON-PARTICIPATING

INDEX

SCHEDULE A

GROUP POLICYHOLDER: [ABC Association]

POLICY NUMBER: [HSMP-ABC]

AGGREGATE AMOUNT MAXIMUM FOR EACH INJURY OR SICKNESS: [$2,000,000.00]

LIFETIME MAXIMUM: [$10,000,000.00]

NOTICE

Customer Service Department
National Health Insurance Company
Post Office Box 619999
Dallas, Texas 75261-6199
(800)237-1900

Agent's Name, Address, and Telephone Number:

Please see the bottom portion of page 4 of your application which is attached to the policy/certificate for the name of your agent. Call our toll-free number above if you should require the agent's address and/or telephone number.

If we at National Health Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact the Consumer Services Division of the Arkansas Department of Insurance at:

1200 West Third Street
Little Rock, Arkansas 72201-1904
(800) 852-5494 or (501) 371-2640
insurance.consumers@arkansas.gov

PART I - UTILIZATION SERVICES

Our UTILIZATION SERVICES Division provides a comprehensive, coordinated program that seeks to assure the highest quality medical care by combining Utilization Review, Second and Third Surgical Opinions, Pre-admission Testing and Case Management of catastrophic conditions.

FOR ALL UTILIZATION SERVICES, YOU OR YOUR PROVIDER MUST CALL [1-800-237-1900]. Emergency Hospital confinements that occur outside normal business hours must be reported within forty-eight (48) hours or on the first business day after admission.

A. UTILIZATION REVIEW

The goal of Our Utilization Review program is for You to receive necessary and appropriate treatment while avoiding unnecessary expenses when a Hospital confinement or outpatient surgical procedure is being considered. All review services are conducted by professional consultants such as registered nurses and social workers who have access to a panel of Physicians, advisors, and/or a Medical Director.

Utilization Review consists of the Pre-Certification of all non-emergency Hospital admissions or outpatient surgical procedures before services are provided, concurrent stay review, and discharge planning.

Utilization Review is not intended as a substitute for the medical judgment of an attending Physician or any other health care provider. However, if a particular treatment is not Pre-Certified when required, it will not be eligible for maximum benefits.

All Utilization Review decisions may be appealed as described in Part IX of the Group Policy and certificate regarding "Claims Appeal" and Part X regarding "Arbitration of Claim Disputes".

1. PRE-CERTIFICATION

   Pre-Certification does not guarantee that benefits will be paid. Payment of benefits will be determined by the Company in accordance with and subject to all of the terms, provisions, limitations, and exclusions of Your coverage under the Group Policy.

   Before You enter a Hospital on a non-emergency basis or schedule an outpatient surgical procedure, Our Utilization Services Division will, in conjunction with Your Physician, review the proposed treatment for medical necessity and appropriateness. A non-emergency Hospital confinement is one which can be scheduled in advance without endangering the health of the patient.

   The Pre-Certification process is set in motion by a telephone call from either You or Your provider to Our Utilization Services Division at the number specified within the second paragraph of this Part I section of the Group Policy and certificate. The following information is required:

   a. name, social security number, and address of the primary Insured;

   b. name of the Insured patient and relationship to the primary Insured;

   c. certificate or ID number;

   d. name and telephone number of the attending Physician;

e. name and address of the Hospital and the proposed date of admission; and

f. diagnosis and/or type of procedure (including outpatient surgery).

If a condition requires an emergency admission to a Hospital, You (or Your representative), the Hospital or the attending Physician must contact Our Utilization Services Division within forty-eight (48) hours or on the first business day after admission.

If the required Pre-Certification procedures are not followed, ELIGIBLE EXPENSES FOR ALL PROVIDERS WILL BE REDUCED BY THIRTY PERCENT (30%). For each Hospital confinement, Our personnel will determine the number of days of confinement which will be authorized for payment. If charges are incurred for days of confinement that were not authorized, NO BENEFITS WILL BE PAYABLE FOR THE UNAUTHORIZED DAYS.

Pre-Certification is valid for thirty (30) days after the confinement or surgical procedure is authorized. If the treatment does not occur as planned, You or the provider must contact Us again to renew the Pre-Certification. If this renewal procedure is not followed, ELIGIBLE EXPENSES FOR ALL PROVIDERS WILL BE REDUCED BY THIRTY PERCENT (30%).

Pre-Certification is not required for Hospital admissions for maternity that do not exceed forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean section, excluding the date of delivery. Maternity stays in excess of these maximums must be requested by Your attending Physician. NO BENEFITS WILL BE PAID FOR EXCESS UNAUTHORIZED DAYS.

2. CONCURRENT STAY REVIEW AND DISCHARGE PLANNING

Our Utilization Services Division will monitor Your Hospital stay and coordinate with Your attending Physician, and the Hospital, either Your scheduled release from the Hospital or an extension of the Hospital admission. If Your attending Physician feels it is Medically Necessary for You to remain in the Hospital for a greater length of time than originally authorized, the attending Physician must request the additional days prior to the end of the Pre-Authorized confinement. NO BENEFITS WILL BE PAYABLE FOR UNAUTHORIZED DAYS.

B. SECOND AND THIRD SURGICAL OPINIONS

Some surgical procedures are performed unnecessarily or inappropriately. In many instances, surgery is only one of several treatment options. In other situations, surgery will not be of any benefit to the patient. In some cases, surgery can be performed on an outpatient basis.

As medical practices change, specific surgical procedures requiring an additional opinion will also change. Our Utilization Services Division will determine whether a second surgical opinion will be required. For those procedures requiring additional opinions, the additional consultations must be with Physicians who are board certified specialists in the area involved and must not have any financial association with the surgeon recommending the surgery.

If a second surgical opinion does not confirm the need for surgery, then a third opinion will be required. If the third opinion does not confirm the necessity for surgery, all Eligible Expenses will be paid if You desire the procedure, subject to all other terms of the coverage provided under the Group Policy. Second and third consultations will be considered as Eligible Expenses and will not be subject to the Calendar Year Deductible or Co-Insurance requirements.

FAILURE TO OBTAIN REQUIRED ADDITIONAL OPINIONS WILL RESULT IN A THIRTY PERCENT (30%) REDUCTION IN THE ELIGIBLE EXPENSES FOR THE SURGICAL PROCEDURE.

C. ROUTINE PRE-ADMISSION TESTING

Benefits will be payable for a covered Injury or Sickness for routine pre-admission laboratory tests and x-ray examinations when performed on an outpatient basis within seven (7) days prior to a Hospital admission, subject to satisfaction of the Calendar Year Deductible and Co-Insurance requirements. The procedures must be required by the condition causing the Hospital confinement and must be performed in place of the same tests and examinations that would otherwise be conducted during the Hospital confinement. Charges incurred will be considered as Eligible Expenses even if the results reveal that the condition requires medical treatment prior to Hospital admission or that the Hospital admission is not required.

D. CASE MANAGEMENT OF CATASTROPHIC CONDITIONS

When a catastrophic Sickness or Injury requires long term care, after being stabilized in a Hospital, You can possibly be discharged from the Hospital into a more cost effective care setting while still maintaining a high quality level of care. The Case Management program is designed for those situations which involve a large cash outlay for expenses that ordinarily would not be covered under the Group Policy.

Case Management is utilized only when:

1. the catastrophic Sickness or Injury occurs while both You and Your Sickness or Injury are covered under the Group Policy;

2. You have been hospitalized and Your attending Physician determines that the condition is stabilized;

3. You continue to require that Your care be managed but You need not be hospitalized to receive the care;

4. Your placement in a new care setting is contemplated, entailing costs which are not ordinarily reimbursable under the Group Policy; and

5. the Company, the Case Manager, Your attending Physician, and Your legal representative agree to the alternate treatment plan.

The Case Manager will coordinate and implement Your Case Management program and will provide information on resources and suggestions for proper treatment plans. Once an agreement has been reached, the Group Policy will reimburse for all expenses incurred, even if those expenses would normally not be considered as Eligible Expenses, subject to the Aggregate Amount Maximum and the Lifetime Maximum amount.

Case Management is a voluntary service with no reduction of benefits or other penalties attached if You choose not to participate.

PART II - BENEFIT LEVELS

The Company accesses Preferred Provider Networks consisting of Hospitals, Physicians, and other specialty types of health care providers and facilities in which the participating providers (hereafter called "Network Providers") have agreed to provide services at a discounted rate to the Company's Insureds. Benefits will be based on Your choice of a health care provider. You will

choose whether to use a Network Provider at the time that services are needed. There is no requirement to commit in advance to utilizing a Network Provider.

A Network Provider Directory will be made available to You which will list all Network Providers in Your general geographic area. The Company will periodically update this information, but since Network Providers can change, You should call [1-800-237-1900] or visit our website at [www.nhic.com] to make sure that the provider is still a Network Provider before You receive medical services.

The following provisions apply to all benefits provided by the Group Policy with the exception of the Enhanced Outpatient Medical Benefit.

A. CALENDAR YEAR DEDUCTIBLES

IN-NETWORK: The In-Network Calendar Year Deductible amount is shown in Schedule A of the certificate. You can meet this Deductible by incurring Eligible Expenses for services received from either Network or Non-Network Providers.

After three (3) individual In-Network Calendar Year Deductibles have been satisfied by any three (3) Insureds within a family, additional In-Network Calendar Year Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

OUT-OF-NETWORK: The Out-of-Network Calendar Year Deductible amount is shown in Schedule A of the certificate. You can meet this Deductible by incurring Eligible Expenses only from Non-Network Providers.

After three (3) individual Out-of-Network Calendar Year Deductibles have been satisfied by any three (3) Insureds within a family, additional Out-of-Network Calendar Year Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

B. BENEFIT AND CO-INSURANCE PERCENTAGES

After satisfaction of the Calendar Year Deductible requirement(s), Eligible Expenses will be paid at the Benefit Percentage shown in Schedule A of the certificate for either In-Network or Out-of-Network services, based on Your choice of provider. You will be responsible for the Co-Insurance percentage shown in Schedule A of the certificate for either In-Network or Out-of-Network services, based on Your choice of provider.

C. CO-INSURANCE MAXIMUMS

The Co-Insurance Maximum amounts are shown in Schedule A of the certificate. There is an In-Network Co-Insurance Maximum amount and an Out-of-Network Co-Insurance Maximum amount. You can meet both these amounts simultaneously with Eligible Expenses incurred for services received from either a Network or a Non-Network Provider, up to the amount of the In-Network Co-Insurance Maximum. After the In-Network Co-Insurance Maximum amount has been satisfied, only Eligible Expenses incurred for services received from a Non-Network Provider can be used to satisfy any remaining Out-of-Network Co-Insurance Maximum amount.

After You meet the In-Network Deductible and In-Network Co-Insurance Maximum amount, additional Eligible Expenses incurred during that same Calendar Year, for services received from a Network Provider, will not be subject to Co-Insurance.

After You meet the Out-of-Network Deductible and Out-of-Network Co-Insurance Maximum amount, additional Eligible Expenses incurred during that same Calendar Year, for services received from a Non-Network Provider, will not be subject to Co-Insurance.

Co-Insurance Maximum amounts apply to each Insured each Calendar Year even though a condition or claim may continue from one (1) Calendar Year to the next. After three (3) Insureds within a family have met the In-Network Co-Insurance Maximum amount in a Calendar Year, additional Eligible Expenses of any Insured within the same family will not be subject to Co-Insurance for the remainder of that same Calendar Year.

This provision applies to all benefits where there is a differential between the amounts payable for services received from Network versus Non-Network Providers:

D. MEDICAL EMERGENCY SERVICES

If You cannot reasonably access a Network Provider, the following emergency care services will be reimbursed at the Network Provider level of benefits until You can reasonably be expected to transfer to a Network Provider:

1. a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital that is necessary to determine whether a Medical Emergency condition exists;

2. necessary emergency care services, including the treatment and stabilization of a Medical Emergency condition; and

3. services originating in a Hospital emergency facility following treatment or stabilization of a Medical Emergency condition.

PART III - ELIGIBLE EXPENSES

Subject to the provisions set forth in this section and all other terms of the Group Policy, charges for the services described in the following paragraphs will qualify as Eligible Expenses and will be considered for payment. All benefits payable are subject to the Aggregate Amount Maximum of [two million dollars ($2,000,000.00)] per Injury or Sickness and a Lifetime Maximum amount of [ten million dollars ($10,000,000.00)] for all combined claim payments for all Insureds.

Eligible Expenses must meet the following requirements in order to be considered for payment:

1. any Injury is sustained or first occurs on or after the Effective Date of Your coverage under the Group Policy and while Your coverage is in force;

2. any Sickness first Manifests itself after the Effective Date of Your coverage under the Group Policy and while Your coverage is in force;

3. the Eligible Expense is incurred while Your coverage under the Group Policy is in force; and

4. any loss for any Pre-Existing Condition, which is not excluded by endorsement or by name or specific description, occurs after You have been covered for twenty-four (24) months under the Group Policy.

A. INPATIENT HOSPITAL EXPENSES

If You receive treatment in a Hospital on an inpatient basis for a covered Injury or Sickness, Eligible Expenses under this benefit will be the Usual and Customary Charges for Hospital expenses incurred in the course of Your treatment, excluding:

1. ambulance charges (covered under separate benefit paragraph);

2. charges for Hospital room and board in excess of the Hospital's most prevalent semi-private room rate (except for Intensive Care Unit charges);

3. charges for personal, comfort, or convenience items such as telephone, television, or radio;

4. take home items, including but not limited to drugs and medicines;

5. charges for any other items or services which are not Medically Necessary; and

6. charges for any days of confinement not authorized in the Pre-Certification or Concurrent Stay Review process.

B. INPATIENT MEDICAL EXPENSES

If You receive treatment in a Hospital on an inpatient basis for a covered Injury or Sickness, Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for the items of medical expense listed herein. The eligible items of expense are:

1. Surgeons' fees for surgical operations;

2. Assistant Surgeons' fees for surgical operations;

3. Anesthesiologists' fees;

4. Physicians' Visits at Hospital (not payable to surgeon or assistant surgeon);

5. Pathologists' fees;

6. Radiologists' fees; and

7. Physiotherapists' fees.

C. OUTPATIENT SURGICAL EXPENSES

If You have a surgical operation that is performed on an outpatient basis in a Physician's office or clinic, Hospital, or ambulatory surgery facility due to a covered Injury or Sickness, the Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for the items of expense listed herein. The eligible items of expense are:

1. Hospital or ambulatory surgery facility fees;

2. Surgeons' fees for surgical operations;

3. Assistant Surgeons' fees for surgical operations;

4. Anesthesiologists' fees;

5. Pathologists' fees; and

6. Radiologists' fees.

D. WELL CHILD CARE

If You incur expenses for preventive and primary care services provided by a Physician or under the supervision of a Physician during unlimited visits for Eligible Dependent children up to the

age of twelve (12) and during three (3) visits per Calendar Year for children ages twelve (12) to twenty-one (21), Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for such services. Preventive and primary care services shall include physical examinations, measurements, sensory screening, neuropsychiatric evaluation, developmental screening and anticipatory guidance. Eligible Expenses will also include hereditary and metabolic screening at birth, urinalysis, tuberculin tests and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy, hypothyroidism, phenylketonuria (PKU), galactosemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas. The Usual and Customary Charges for immunization services, without application of the Calendar Year Deductible or Co-Insurance, will also be considered as Eligible Expenses under this benefit.

In addition, Eligible Expenses under this benefit include the Usual and Customary Charges incurred for routine Hospital nursery care and pediatric charges for a child born to the Insured named in Schedule A of the certificate on or after the Effective Date of the certificate. Benefits will be payable for up to five (5) full days in a Hospital nursery or until the parent is discharged from the Hospital following the birth of the child, whichever is the lesser period of time. Eligible Expenses for the child will be subject to the Calendar Year Deductible and Co-Insurance for the child.

E. DIABETES SERVICES

If You have been diagnosed with insulin-dependent, insulin-using, gestational, or non-insulin using diabetes or elevated blood glucose levels resulting from another medical condition, Eligible Expenses under this benefit will be the Usual and Customary Charges for Medically Necessary equipment, supplies, and services which are provided or prescribed by a Physician in the course of Your treatment.

Eligible Expenses will also include the Usual and Customary Charges for outpatient self-management training and education, including medical nutritional therapy when prescribed by Your Physician.

F. HOME HEALTH CARE

If You incur expenses for Home Health Care, such expenses will qualify as Eligible Expenses if:

1. expenses are incurred beginning within fourteen (14) days after being discharged from a Hospital where treatment was received for a covered Injury or Sickness;

2. Your Physician certifies that without Home Health Care, You would have to remain Hospital confined to receive proper treatment;

3. You continue to need care and treatment in Your place of residence; and

4. Your Physician submits a Home Health Care plan in writing to the Company.

Eligible Expenses under this benefit will be the Usual and Customary Charges for Home Health Care for the following services, to a maximum of [twenty thousand dollars ($20,000.00)] per Calendar Year per Insured.

Skilled Nursing Care
Physical Therapy
Occupational Therapy
Medical/Social Work
Nutritional Services
Respiratory Therapy
Speech Therapy
Medical Appliances and Equipment
Prescription Drugs
Laboratory Services
Home Health Aid Visits

Home Health Care does not include and no benefits will be payable for custodial care or services or supplies not included in the Home Health Care plan submitted by Your Physician.

The Company's Case Management Services will be available to You and Your family. There is no reduction of benefits or other penalties attached if You choose not to utilize these services.

G. HOSPICE CARE

If You should require Hospice Care for a covered Injury or Sickness, Eligible Expenses under this benefit will be the Usual and Customary Charges for Hospice Care to a lifetime maximum per Insured of the lesser of one hundred eighty (180) days or [ten thousand dollars ($10,000.00)], if:

1. Your Physician certifies that Your life expectancy is less than six (6) months;

2. Your Physician recommends a Hospice Care program for Your benefit and that of Your immediate family;

3. the services and supplies are ordered by a Physician who directs the Hospice Care program; and

4. the services and supplies are provided to reduce or abate pain or other symptoms of distress and to meet the stresses of dying.

The Company's Case Management Services will be available to You and Your family. There is no reduction of benefits or other penalties attached if You choose not to utilize these services.

H. AMBULANCE

If You require transportation by ambulance for treatment of a covered Injury or Sickness, Eligible Expenses under this benefit will be such ambulance transportation expenses to a maximum of [five hundred dollars ($500.00)] per Insured per Calendar Year.

I. WOMEN'S HEALTH AND CANCER RIGHTS

The United States Congress passed legislation effective October 21, 1998 which requires individual and group health plans to provide reconstructive surgery benefits if the plan normally provides medical and surgical benefits for a mastectomy. The required coverage consists of:

1. reconstruction of the breast on which the mastectomy was performed; and

2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. prostheses and physical complications from all stages of a mastectomy including lymphedemas.

These benefits must be provided in a manner determined in consultation with the attending provider and the patient. The coverage will be subject to the same Deductible, Co-Insurance, and other benefit provisions as for similar types of expenses covered under the plan for other Sicknesses. These benefits will not duplicate any other benefits payable under the plan. Coverage provided will be in accordance with federal and state law and applicable regulations.

J. ENHANCED OUTPATIENT MEDICAL BENEFIT

This paragraph is NOT SUBJECT to the Calendar Year Deductibles, Benefit Percentages, Co-Insurance Percentages, or Co-Insurance Maximums shown in Schedule A of the certificate. Separate Deductible amounts, benefit percentages, and co-insurance maximum apply to this paragraph. Eligible Expenses incurred under this benefit may not be used to

satisfy the Calendar Year Deductibles or Co-Insurance Maximums shown in Schedule A of the certificate.

The Enhanced Outpatient Medical Benefit Deductible amounts are shown in Schedule A of the certificate and apply to each Insured each Calendar Year. There is an In-Network Deductible amount and an Out-of-Network Deductible amount. These Deductible amounts may be satisfied only with Eligible Expenses incurred under the Enhanced Outpatient Medical Benefit.

You can meet the In-Network Enhanced Outpatient Medical Benefit Deductible amount by incurring Eligible Expenses for services received from either Network or Non-Network Providers. After three (3) total In-Network Deductibles have been satisfied by any three (3) Insureds within a family, additional In-Network Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

You can meet the Out-of-Network Enhanced Outpatient Medical Benefit Deductible amount by incurring Eligible Expenses only from Non-Network Providers. After three (3) total Out-of-Network Deductibles have been satisfied by any three (3) Insureds within a family, additional Out-of-Network Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

Eligible Expenses are the Usual and Customary Charges incurred for THE FOLLOWING outpatient services/treatments which You receive in a Physician's office or clinic, Hospital, or ambulatory surgery facility due to a covered Injury or Sickness. After the Deductible requirement(s) have been met from Eligible Expenses, benefits will be paid at [eighty percent (80%)] of Usual and Customary Charges for services received from a Network Provider or [sixty percent (60%)] of Usual and Customary Charges for services received from a Non-Network Provider for the next [ten thousand dollars ($10,000)] of Eligible Expenses. Thereafter, during that same Calendar Year, Eligible Expenses will be paid at [one hundred percent (100%)] of Usual and Customary Charges. You are responsible for the Deductible requirement(s), Your portion of Eligible Expenses incurred after the Deductible is satisfied, and any non-covered charges. These benefit payment provisions apply to the expenses incurred for each Insured individually.

Pathology (Lab. Services)
Radiology (X-Rays)
Upper/Lower G.I. Series
CAT Scans
Magnetic Resonance Imaging
Nerve Conduction Studies
Emergency Room Facility Fees
Non-Surgical Anesthesia
Casts, Splints & Braces
Surgical Dressings
Central Supplies
Kidney Dialysis
Chemotherapy Treatments
Cobalt Treatments
Irradiation Treatments
Ultrasound
Sonograms
Myelograms
Pyelograms
Angiograms
Electrocardiograms
Electroencephalograms
Electromyograms
Pneumoencephalograms
Durable Medical Equipment - Maximum of $2,500 per Insured per Calendar Year.
Physical Therapy - Not to exceed the lesser of 25 treatments or $2,000 per Insured per Calendar Year.
Occupational Therapy - Not to exceed the lesser of 25 treatments or $2,000 per Insured per Calendar Year.

Total benefits provided will be **LIMITED TO THOSE SERVICES LISTED ABOVE** and shall not exceed [two hundred fifty thousand dollars ($250,000.00)] of Eligible Expenses per Insured per Calendar Year. Kidney dialysis must be received in a Medicare approved dialysis center. This benefit does not provide coverage for Physician fees (including but not limited to Physician fees for office or clinic visits, routine physical exams, or surgery), prescription drugs or any other service not specifically listed.

K. MAMMOGRAPHY AND CYTOLOGIC SCREENING

This benefit is NOT SUBJECT to satisfaction of the Calendar Year Deductibles or Co-Insurance.

If You receive any of the following services, Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for such services. The eligible services are:

1. an annual cervical cytologic screening for a female Insured;

2. any cervical cytologic screening for a female Insured which her Physician certifies to be Medically Necessary;

3. a baseline mammogram and annual mammograms thereafter for a female Insured; and

4. any mammogram for a female Insured which is certified to be Medically Necessary by her Physician or which is recommended by her Physician where such Insured or her mother or sister has had a history of breast cancer.

Eligible Expenses for cervical cytologic screening include only the laboratory charges for the test and do not include the Physician office visit charge.

L. PROSTATE CANCER SCREENING

This benefit is NOT SUBJECT to satisfaction of the Calendar Year Deductibles.

Eligible Expenses under this benefit will be the Usual and Customary Charge for prostate cancer screening performed by a Physician in accordance with the National Comprehensive Cancer Network guidelines in effect as of January 1, 2009 for the ages, family histories, and frequencies referenced in such guidelines. If a Physician recommends that You undergo a prostate specific antigen blood test, We may not deny coverage for the test on the basis of a previous negative digital rectal examination.

M. TREATMENT OF CATASTROPHIC METABOLIC DISORDERS

If You have been diagnosed with a Catastrophic Metabolic Disorder, Eligible Expenses under this benefit will be charges incurred for Medically Necessary amino acid modified preparations, Medical Foods, Low Protein Modified Food Products and any other special dietary products and formulas prescribed and administered by a Physician for the therapeutic treatment of Catastrophic Metabolic Disorders which are in excess of two thousand four hundred dollars ($2,400.00) in a Calendar Year.

"Catastrophic Metabolic Disorder" means phenylketonuria (PKU), galactosemia, organic acidemias, and disorders of amino acid metabolism.

"Inherited Metabolic Disease" means a disease caused by an inherited abnormality of body chemistry.

"Low Protein Modified Food Product" means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease.

"Medical Food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

N. MUSCULOSKELETAL DISORDERS OF THE FACE, NECK OR HEAD

Eligible Expenses under this benefit are the Usual and Customary Charges incurred for surgical or nonsurgical medical treatment of a musculoskeletal disorder affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder. Coverage will be provided for Medically Necessary diagnosis and treatment of these conditions regardless of cause and whether prescribed or administered by a dentist or a Physician. Benefits will be payable only to the same extent as for any other Sickness covered under the Group Policy.

O. COLORECTAL CANCER SCREENING

Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for Colorectal Cancer Screening for Insureds who are:

1. fifty (50) years of age or older;

2. less than fifty (50) years of age but who are at High Risk for Colorectal Cancer; or

3. Symptomatic of Colorectal Cancer as determined by a Physician.

Benefits for Colorectal Cancer Screening services will include an examination of the entire colon including the following examinations and laboratory tests:

1. an annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;

2. a double-contrast barium enema every five (5) years; or

3. a colonoscopy every ten (10) years.

The Insured will determine the choice of screening strategies in consultation with a Physician. Benefits will also include any additional medically recognized screening tests for colorectal cancer required by the Director of the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations.

This benefit will also include coverage for follow-up screenings based on the following guidelines:

1. if an initial colonoscopy was normal, a follow-up screening after ten (10) years;

2. if the Insured had one (1) or more neoplastic polyps or adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, a follow-up screening after three (3) years;

3. if the Insured had a single tubular adenoma of less than one centimeter (1 cm), a follow-up screening after five (5) years; or

4. if the Insured had large sessile adenomas greater than three centimeters (3 cm), especially if removed in a piecemeal fashion, a follow-up screening in six (6) months or until complete polyp removal is verified by colonoscopy.

"High Risk for Colorectal Cancer" means:

1. the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy;

2. a family history of colorectal cancer in close relatives such as parents, brothers, sisters, or children;

3. genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis;

4. a personal history of colorectal cancer, ulcerative colitis, or Crohn's disease;

5. the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; or

6. any additional or expanded definition of "High Risk for Colon Cancer" as recognized by medical science and determined by the Director of the Division of Health of the Department of Health and Human Services in consultation with the University of Arkansas for Medical Sciences.

"Symptomatic of Colorectal Cancer" includes:

1. bleeding from the rectum or blood in the stool; or

2. a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

P. SPEECH OR HEARING IMPAIRMENT

Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for the necessary care and treatment of loss or impairment of speech or hearing. "Loss or Impairment of Speech or Hearing" shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of the provider's area of certification.

This benefit will include coverage for a hearing aid purchased from a professional licensed in the state of Arkansas to dispense a hearing aid. The maximum benefit amount payable for a hearing aid is one thousand four hundred dollars ($1,400.00) per ear in a three year period and is not subject to Deductible or Co-Insurance requirements.

"Hearing aid" means an instrument or device, including repair and replacement parts, that:

1. is designed and offered for the purpose of aiding persons with or compensating for impaired hearing;

2. is worn in or on the body; and

3. is generally not useful to a person in the absence of a hearing impairment.

Q. ORTHOTIC DEVICES/SERVICES AND PROSTHETIC DEVICES/SERVICES

Eligible Expenses under this benefit will be eighty percent (80%) of Medicare allowable charges as defined by the Center for Medicare and Medicaid Services Healthcare Common Procedure Coding System as of January 1, 2009 or as later revised, for the following Medically Necessary items prescribed and provided by a Physician:

1. an Orthotic Device;

2. an Orthotic Service;

3. a Prosthetic Device; and

4. a Prosthetic Service.

This benefit will include Medically Necessary replacement once every three (3) years unless more frequent replacement is Medically Necessary. Coverage will include replacement or repair necessitated by anatomical change or normal use of an Orthotic or Prosthetic Device unless the repair or replacement is due to misuse or loss. If We deny or limit coverage under this benefit based on lack of Medical Necessity, External Review is available to You as described in Part IX.H. of the Group Policy and certificate.

"Orthotic Device" means an external device that is intended to restore physiological function or cosmesis to a patient and is custom made, fitted, or adjusted for the patient. Orthotic Device does not include a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that is carried in stock by the seller and sold without therapeutic modification and has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

"Orthotic Service" means the evaluation and treatment of a condition that requires the use of an Orthotic Device.

"Prosthetic Device" means an external device that is intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and that is custom made, fitted, or adjusted for the patient. Prosthetic Device does not include an artificial eye, a dental appliance, a cosmetic device such as eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

"Prosthetic Service" means the evaluation and treatment of a condition that requires the use of a Prosthetic Device.

PART IV - EXCLUSIONS AND LIMITATIONS

No payment will be made for claims resulting in or from:

1. a Pre-Existing Condition, which is not excluded by endorsement or by name or specific description, unless the expense is incurred after You have been covered for more than twenty-four (24) months under the Group Policy, excluding newborns and adoptees as provided in Part VI of the Group Policy and certificate;

2. any Injury that was sustained prior to Your Effective Date of coverage under the Group Policy;

3. normal childbirth;

4. prenatal care;

5. Mental or Emotional Disorders, unless specifically provided in the Group Policy due to state mandates and described in the certificate;

6. treatment for alcohol or chemical substance use, abuse, or dependency or illegal drug use or experimentation, unless specifically provided in the Group Policy due to state mandates and described in the certificate;

7. any loss incurred where a contributing factor to the loss was You being Intoxicated or under the influence of any substance which has the capacity to disturb Your mental, emotional, or physical faculties, unless administered on the advice of a Physician;

8. any expenses which exceed the Usual and Customary Charges;

9. any expenses incurred which are not Medically Necessary;

10. aviation (while acting as a pilot or crew member);

11. war or act of war (declared or undeclared);

12. participation in a felony, riot or insurrection;

13. service in the armed forces or units auxiliary thereto (upon notice of Your entry into the armed forces or units auxiliary thereto, You will receive a partial refund of unearned premiums, if any);

14. suicide or intentionally self-inflicted harm;

15. cosmetic surgery, except that surgery resulting from a covered Injury or covered Sickness and reconstructive surgery because of congenital disease or anomaly which has resulted in a functional defect of an Eligible Dependent child born to or placed for adoption with the Insured named in Schedule A of the certificate on or after its Effective Date;

16. breast reduction or augmentation even if Medically Necessary, unless due to reconstructive surgery which is needed as a result of a mastectomy performed due to a diagnosis of breast cancer;

17. dental care or treatment, except that dental treatment caused by an Accidental Injury;

18. weight loss procedures even if Medically Necessary;

19. voluntary abortions, sterilization procedures, or reversals of sterilization procedures;

20. penile implants even if Medically Necessary;

21. sex transformation procedures, hormones for such treatment and charges for related psychiatric care or counseling;

22. infertility treatment including but not limited to artificial insemination, in vitro fertilization, or embryo transfer procedures;

23. experimental treatment or experimental surgery not recognized by the American Medical Association, or considered to be experimental or investigational by any appropriate health care technological assessment body established by a state or federal government;

24. Radial Keratotomy or similar procedures to improve vision, eyeglasses, contact lenses, and examination for the prescription or fitting thereof;

25. any loss covered by worker's compensation, employer's liability benefits, or occupational disease law;

26. services performed by a member of Your family, services for which no charge is normally made in the absence of insurance, or services of a federal, veterans', state or municipal Hospital (unless You are financially responsible for the charges);

27. any expenses paid for under another part of the Group Policy;

28. legal expenses, whether or not incurred to obtain medical treatment;

29. any expense for which Medicare benefits are payable (benefits will not be reduced or denied because the medical expense was covered by the Medical Assistance Act of 1967, better known as Medicaid);

30. routine physical examinations for adult Insureds unless specifically provided in the Group Policy due to state mandates and described in the certificate; and

31. any item not specifically listed in the Group Policy and certificate as a benefit.

PART V - DEFINITIONS

A. "ACCIDENT/ACCIDENTAL" means any sudden or unforeseen event which results in accidental bodily Injury sustained by an Insured which is the direct cause, independent of disease or bodily infirmity or any other cause, and occurs while the Insured's coverage under the Group Policy is in force.

B. "AGGREGATE AMOUNT MAXIMUM" means the maximum amount of Eligible Expenses that will be covered under the Group Policy for each Injury or Sickness with respect to each Insured. The Aggregate Amount Maximum is shown in Schedule A.

C. "ASSOCIATION" means the Group Policyholder as shown in Schedule A.

D. "CALENDAR YEAR" means the period beginning January 1 of any year and ending December 31 of the same year.

E. "CO-INSURANCE" means the percentage of Eligible Expenses that are to be paid by You based on Your choice of Provider, after satisfaction of the Calendar Year Deductible requirements. The Co-Insurance Percentages are shown in Schedule A of the certificate unless specified otherwise in the benefit description.

F. "CO-INSURANCE MAXIMUM" means the total amount of Eligible Expenses that each Insured is required to incur each Calendar Year, after satisfaction of the Calendar Year Deductible requirements, before the Group Policy will pay one hundred percent (100%) of all additional Eligible Expenses incurred for that Insured during that Calendar Year.

The Co-Insurance Maximum amounts are shown in Schedule A of the certificate. There is an In-Network Co-Insurance Maximum amount and an Out-of-Network Co-Insurance Maximum amount. Eligible Expenses which are not subject to payment of Co-Insurance cannot be used to satisfy the Co-Insurance Maximums.

Co-Insurance Maximum amounts apply to each Insured each Calendar Year even though a condition or claim may continue from one (1) Calendar Year to the next. After three (3) Insureds within a family have met the In-Network Co-Insurance Maximum amount in a Calendar Year, additional Eligible Expenses of any Insured within the same family will not be subject to Co-Insurance for the remainder of that same Calendar Year.

G. "COMPLICATIONS OF PREGNANCY" means:

1. Hospital confinement required to treat conditions, such as the following, in a pregnant female: acute nephritis; nephrosis; cardiac decompensation; HELLP syndrome; uterine rupture; amniotic fluid embolism; chorioamnionitis; fatty liver in pregnancy; septic abortion; placenta accreta; gestational hypertension; puerperal sepsis; peripartum cardiomyopathy; cholestasis in pregnancy; thrombocytopenia in pregnancy; placenta previa; placental abruption; acute cholecystitis and pancreatitis in pregnancy; postpartum hemorrhage; septic pelvic thromboplebitis; retained placenta; venous air embolus associated with pregnancy; miscarriage; or an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of

descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section.

2. Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism; hepatitis B or C; HIV; Human papilloma virus; abnormal PAP; syphilis; Chlamydia; herpes; urinary tract infections; thromboembolism; appendicitis; hypothyroidism; pulmonary embolism; sickle cell disease; tuberculosis; migraine headaches; depression; acute myocarditis; asthma; maternal cytomegalovirus; urolithiasis; DVT prophylaxis; ovarian dermoid tumors; biliary atresia and/or cirrhosis; first trimester adnexal mass; hyditidiform mole; or ectopic pregnancy.

H. "DEDUCTIBLE" means the amount of Eligible Expenses for which no benefits are payable in any one Calendar Year. The Calendar Year Deductibles are based on Your choice of provider and are shown on the Schedule A page of the certificate. The Deductible is Your sole responsibility and must be satisfied by incurring charges which are Eligible Expenses under the terms of the Group Policy, excluding those Eligible Expenses that are not subject to the Calendar Year Deductible. Part II.A. of the Group Policy and the certificate sets forth the Deductible requirements.

If two (2) or more Insureds in the same family are injured in the same Accident, only one (1) Deductible and one (1) Co-Insurance Maximum amount will be required during that Calendar Year for all Eligible Expenses resulting from Injuries sustained in the Accident.

Certain benefits under the Group Policy may not be subject to the Calendar Year Deductibles shown in Schedule A of the certificate. These benefits may instead be subject to a separate Deductible for that particular benefit. These types of provisions are set forth in the description for the particular benefit.

I. "EFFECTIVE DATE" means the date shown in Schedule A of the certificate on which coverage begins for Insureds who were listed on the original application and for whom issuance of coverage was approved. The Effective Date of coverage for an Insured who is added at a later date will be shown on an endorsement which will be issued by the Company to provide evidence of the addition.

J. "ELIGIBLE DEPENDENT(S)" means:

1. the legal spouse of the Insured named in Schedule A of the certificate;

2. an unmarried child of either the Insured named in Schedule A of the certificate or that Insured's legal spouse, who is:

   a. less than nineteen (19) years old;

   b. less than twenty-four (24) years old and in regular full-time attendance at any college or university accredited as an institution of higher learning. "Full-time attendance" shall mean twelve (12) credit hours per semester; or

   c. medically certified as disabled and dependent upon the Insured named in Schedule A of the certificate, regardless of age.

"Spouse" includes a domestic partner or participant in a civil union if the relationship is legally recognized in Your state or jurisdiction of residence.

"Child" includes a natural child, a legally adopted child, or a child placed for adoption with the Insured named in Schedule A of the certificate on or after its Effective Date. "Child" also includes a minor grandchild, niece, or nephew who is under the primary care of the Insured named in Schedule A of the certificate, if the legal guardian of the child other than the Insured named in Schedule A of the certificate is not covered by an accident and sickness plan. "Primary care" means the provision of food, clothing, and shelter on a regular and continuous basis during the time that public school is in regular session.

K. "ELIGIBLE EXPENSES" are those benefits contained in the Group Policy and described in the certificate. Services and materials will be considered Eligible Expenses only to the extent that:

1. expenses do not exceed the Usual and Customary Charges;

2. expenses are incurred while Your coverage is in force under the Group Policy; and

3. services and materials are Medically Necessary and are furnished at the direction of or under the supervision of a Physician.

L. "HOME HEALTH CARE" means care which is provided by a public or private agency that specializes in giving nursing and other therapeutic services in Your home or place of residence. The agency must be licensed as such or, if no license is required, approved by a state department or agency having authority over Home Health Care.

M. "HOSPICE CARE" means treatment provided by a public agency or private organization which meets all of the following requirements:

1. is primarily engaged in providing care to terminally ill patients;

2. provides twenty-four (24) hour care to control the symptoms associated with terminal Sickness;

3. has on its staff an interdisciplinary team which includes at least one (1) Physician, one (1) registered nurse (RN), one (1) social worker, and at least one (1) pastoral or other counselor, and volunteers;

4. is a licensed organization whose standards of care meet those of the National Hospice Organization;

5. maintains central clinical records on all patients;

6. provides appropriate methods of dispensing drugs and medicines; and

7. offers a coordinated program of home care and inpatient care for a terminally ill patient and the patient's family.

The term "Hospice" does not include any organization or part thereof which is primarily engaged in providing custodial care, or care for drug abusers, drug addicts, alcohol abusers, or alcoholics, or domestic services, a place of rest, a place for the aged, or a hotel or similar institution.

N. "HOSPITAL" means only an institution which meets the following requirements:

1. is an institution operated pursuant to law; and

2. is primarily engaged in providing or operating - either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under supervision of a staff of one (1) or more duly licensed Physicians - medical, diagnostic and surgical

facilities for medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

3. provides twenty-four (24) hour nursing service by or under the supervision of registered nurses (RNs).

The term "Hospital" also means ambulatory surgical center, provided that any services performed therein would have been covered under the terms of the Group Policy as an eligible inpatient service.

This definition shall not include an institution, or that part of an institution, operating primarily:

1. as a convalescent home, rest, nursing, or convalescent facility; or

2. as a facility affording custodial or educational care, or a facility for the aged; or

3. as a military Hospital, veterans' Hospital, or soldiers' home or any institution contracted for or operated by the federal government or any agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered where a legal liability exists for charges made to the individual for such services.

O. "INJURY" means bodily harm caused by an Accident, directly and independently of all other causes. The Injury must occur while Your coverage is in force.

P. "INSURED" means the Association member named in Schedule A of the certificate and all covered Eligible Dependents.

Q. "INTOXICATED/INTOXICATION" means a level of blood alcohol content that is specified in the laws defining Intoxication in the state where the loss or cause of loss occurred.

R. "LIFETIME MAXIMUM" means the maximum amount of Eligible Expenses that will be covered under the Group Policy for all claims submitted by the Insured named in Schedule A of the certificate and his or her covered Eligible Dependents, after which coverage for that Insured and his or her Eligible Dependents will become null and void. The Lifetime Maximum is shown in Schedule A.

S. "MANIFESTS/MANIFESTED" means that a condition is active and that there is a distinct symptom (or symptoms) from which a Physician could diagnose the condition with reasonable accuracy or when a symptom (or symptoms) is of sufficient severity to cause a person to seek medical diagnosis or treatment.

T. "MEDICAL EMERGENCY" means the sudden onset or sudden worsening of a medical condition which is evidenced by symptoms of such severity, including severe pain, that a failure to immediately provide medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

1. placing the patient's mental or physical health in serious jeopardy;

2. serious impairment to bodily functions;

3. serious dysfunction of any bodily organ or part;

4. serious disfigurement; or

5. in the case of a pregnant woman, serious jeopardy to the health of a fetus.

U. "MEDICALLY NECESSARY" means a service or supply which is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on current generally accepted medical practice. A service or supply will not be considered as Medically Necessary if:

1. it is provided only as a convenience to You or a health care provider;

2. it is not appropriate treatment for Your diagnosis or symptoms;

3. it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or

4. it is part of a plan of treatment that is experimental, unproven or related to a research protocol, in the sense that its effectiveness is not generally recognized by the medical community.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

V. "MEDICAID" means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

W. "MEDICARE" means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

X. "MENTAL OR EMOTIONAL DISORDER" means a neurosis, psychoneurosis, psychosis, or a mental or emotional disease or disorder of any kind as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

Y. "NETWORK PROVIDER" means any Hospital, Physician or other provider of medical services that has contracted with Preferred Provider Networks to furnish such services at discounted rates to the Company's Insureds. A provider who has terminated his/her contract with the Preferred Provider Network is not a "Network Provider".

Z. "NON-NETWORK PROVIDER" means any Hospital, Physician, or other provider of medical services that does not have a contract to provide services at discounted rates to the Company's Insureds through a Preferred Provider Network.

AA. "PHYSICIAN" means a duly licensed Doctor of Medicine, Osteopath, Podiatrist, Chiropractor, Midwife, Nurse Anesthetist, Psychologist or any other health care practitioner providing a covered service and acting within the scope of his or her license who is required to be recognized by any law applicable to health insurance in the state where the service is provided. The term "Physician" does not include the Insured or an Insured's close relative - spouse, domestic partner, parent, sister, sister-in-law, brother, brother-in-law, aunt, uncle, grandparent, niece, nephew, child or cousin - or an individual residing in an Insured's household.

BB. "PRE-CERTIFICATION/PRE-CERTIFIED" means the process described in Part I of the Group Policy and the certificate whereby Our Utilization Services Division reviews a proposed non-emergency Hospital confinement, outpatient surgical procedure or emergency Hospital confinement for medical necessity and appropriateness.

CC. "PRE-EXISTING CONDITION" means the existence of symptoms which would cause a person to seek diagnosis, care or treatment within the twelve (12) month period preceding the Effective Date of coverage under the Group Policy;

OR

a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within the twelve (12) month period preceding the Effective Date of coverage under the Group Policy.

DD. "SCHEDULE A" means the schedule found on page 3.

EE. "SICKNESS" means an illness or disease which first Manifests itself after the Effective Date of Your coverage under the Group Policy and while such coverage is in force. Sickness includes congenital illnesses or defects in newborn Eligible Dependents or children placed for adoption with the Insured named in Schedule A of the certificate on or after its Effective Date.

Sickness also includes Complications of Pregnancy which occur after Your Effective Date of coverage under the Group Policy. Sickness does not include normal pregnancy.

FF. "TOTALLY DISABLED/TOTAL DISABILITY" means:

1. with respect to the Insured named in Schedule A of the certificate, or a covered spouse or domestic partner, that he or she is unable to perform, by reason of Injury or Sickness, the material and substantial duties of his or her occupation and is under the regular care and attendance of a Physician for the condition causing the Total Disability;

2. with respect to an Eligible Dependent, other than a covered spouse or domestic partner, that he or she is prevented, by reason of Injury or Sickness, from engaging in the normal and customary duties and activities of a person of like age and sex, and is under the regular care and attendance of a Physician for the condition causing the Total Disability.

GG. "USUAL AND CUSTOMARY CHARGES" means:

1. For services provided by Network Providers: the contracted rate in effect for that Network Provider on the date that the service is provided to an Insured; or

2. For services provided by a Non-Network Provider: charges for medical services or supplies which are in an amount not exceeding the normal rates charged for the same or similar services or supplies in the geographic region where the service or supply is furnished. Geographic region is a zip code, city, county, or such area as is necessary to obtain a representative cross section of medical and Hospital costs.

HH. "WE", "US", or "OUR" means the National Health Insurance Company. Also referred to as the "Company".

II. "YOU" and "YOUR" means all Insureds.

PART VI - ELIGIBILITY PROVISIONS

A. ELIGIBILITY AND EFFECTIVE DATE

1. EFFECTIVE DATE

   Persons who apply for this coverage must provide evidence of insurability satisfactory to the Company in order for the Company to issue coverage. The Effective Date is shown in Schedule A of the certificate for all applicants listed on the original application for

insurance. The Effective Date for Eligible Dependents who apply for coverage at a later date will be the first day of the month following the date on which the Company approves the Eligible Dependent's insurability, except for newborns and adoptees as provided in the following paragraphs.

2. NEWBORN CHILDREN

   If a child is born to the Insured named in Schedule A of the certificate on or after the Effective Date of the certificate, the child will be immediately covered under the Group Policy as of the moment of birth. This automatic coverage will cease at the end of ninety (90) days. To continue coverage beyond the ninety (90) day period, You must notify Us in writing at the address shown on page 1 of the certificate prior to the end of the automatic coverage, of Your desire to add the child permanently to Your coverage. Any premium due for the continued coverage must also be submitted within the ninety (90) day period. A Pre-Existing Condition exclusion period will not be applied to the newborn.

3. ADOPTED CHILDREN

   Any minor child under the charge, care and control of the Insured named in Schedule A of the certificate whom the Insured has filed a petition to adopt on or after the Effective Date of the certificate will be immediately covered under the Group Policy. Coverage will begin on the date of the filing of a petition for adoption if the Insured applies for coverage within sixty (60) days after the filing of such petition for adoption. For a newborn adoptee, coverage will begin from the moment of birth if the petition for adoption and application for coverage are filed within sixty (60) days after the child's birth. A Pre-Existing Condition exclusion period will not be applied to the adoptee. Coverage for any prospective adoptee will cease upon termination of the application for adoption.

B. TERMINATION OF INSURANCE

1. Coverage for the Insured named in Schedule A of the certificate will terminate upon the earliest of:

   a. the date on which the required premium is not paid, subject to the "Grace Period" provision in Part VIII of the Group Policy and certificate;

   b. the date on which the Insured ceases to be a member of the Association to which the Group Policy is issued;

   c. the death of the Insured;

   d. the date on which You perform an act or practice that constitutes fraud or make an intentional misrepresentation of material fact under the terms of the Group Policy; or

   e. the date on which the Group Policy or all individual health insurance coverage as defined by Public Law 104-191 is terminated in Your state in accordance with Public Law 104-191 and any applicable state law.

2. Coverage for an Eligible Dependent will cease on the earliest of:

   a. the date on which coverage for the Insured named in Schedule A of the certificate terminates as described in paragraph one of this section; or

   b. the last day of the premium month in which a dependent ceases to meet the definition of an Eligible Dependent.

If an identifiable premium is accepted after the termination date for an Eligible Dependent, coverage for that dependent will continue in force until the end of the period for which premium has been paid.

C. CONTINUATION OF COVERAGE

1. TERMINATION OF EMPLOYMENT OR MEMBERSHIP: Any Insured whose coverage under the Group Policy would otherwise terminate due to termination of employment or membership in the Association may continue coverage under the Group Policy as provided herein. To have the right to continue coverage, the Insured must have been covered under the Group Policy, or any it replaced, for at least three (3) months prior to the date coverage would terminate.

   Continuation of coverage shall not be available to an Insured who is eligible for full coverage under any other group coverage, including coverage for any Pre-Existing Conditions the Insured may have.

   An Insured who wishes to continue coverage must submit a written request for continuation to Us within ten (10) days after the termination of employment or membership.

   An Insured who requests continuation of coverage must pay the premium required on a monthly basis in advance, subject to the provisions of Part VIII.A. of the Group Policy and certificate.

   Continuation of coverage shall end upon the earliest of:

   a. one hundred twenty (120) days after continuation of coverage began;

   b. the date on which the required premium is not paid, subject to the "Grace Period" provision in Part VIII.A. of the Group Policy and certificate; or

   c. the date the Group Policy terminates.

   At the termination of the continued coverage, the Insured shall be eligible for a conversion policy, subject to the provisions of Part VI.E. "Medical Benefits Conversion Right".

2. LOSS OF ELIGIBILITY AS AN ELIGIBLE DEPENDENT: If an Eligible Dependent's coverage terminates as set forth in paragraph B.2., of this Part VI of the Group Policy and certificate, due to reaching the limiting age or a change in marital status, the Eligible Dependent may continue coverage without providing evidence of insurability by making the required premium payments for issuance of his or her own certificate and by becoming a dues paying member of the Association to which the Group Policy is issued. The Eligible Dependent must submit a written request for this continuation of coverage within thirty-one (31) days of the date on which coverage would otherwise terminate.

D. EFFECT OF MENTAL OR PHYSICAL HANDICAP ON TERMINATION

An unmarried Eligible Dependent's insurance may be kept in force past the date it would have ended due to age if:

1. prior to reaching that age, the Eligible Dependent is not able to earn a living due to mental or physical handicap; and

2. the Eligible Dependent remains dependent on the Insured named in Schedule A of the certificate for the majority of his or her support.

As evidence that the handicap still exists, written proof will be required, but not more often than once a year. The proof must be submitted in a form required by the Company. The handicap will be considered to have ceased if the required proof is not received when due. Otherwise, insurance of the Eligible Dependent will end when:

1. the handicap ceases; or

2. it would end for reasons other than the Eligible Dependent's age.

E. MEDICAL BENEFITS CONVERSION RIGHT

1. NATURE OF THE CONVERSION RIGHT: This right applies if You lose coverage under the Group Policy except as specified herein. You may convert, without providing evidence of insurability, to a Guaranteed Renewable Conversion Policy offering similar coverage. This right is subject to the terms of this section.

   The premium rate for the conversion policy will be based on Your current age under the converted certificate.

   You may not convert if benefits under the Group Policy cease because:

   a. premium contributions were not paid when due;

   b. benefits are replaced by similar group coverage within thirty-one (31) days; or

   c. termination of coverage is due to a complete withdrawal by the Company from the individual market in the state as allowed under state and federal law.

   To convert, You must submit the following within thirty-one (31) days of termination of coverage:

   a. written application; and

   b. the first premium payment.

2. PERSONS COVERED UNDER A CONVERSION POLICY: Any Insured who was covered under the certificate on the date of termination.

   At Our option, a separate conversion policy will be issued to each Eligible Dependent.

3. FORM OF THE CONVERSION POLICY: The conversion policy will be on a form that is allowed in the state in which it is issued.

   The benefit level of the conversion policy will not exceed the benefit level of the certificate at the time of termination. Benefit levels will take into account:

   a. stated dollar amounts;

   b. co-insurance percentages;

   c. established maximums; and

   d. deductibles.

4. EFFECTIVE DATE OF THE CONVERSION POLICY: The conversion policy will take effect on the day following termination of eligibility for medical benefits under the Group Policy.

5. PREMIUM MODE: The initial conversion premium must be quarterly.

F. EXTENSION OF MEDICAL BENEFITS

If You are Totally Disabled at the time insurance terminates, Your coverage will continue during such Total Disability but only for the bodily Injury or Sickness causing the disability. The maximum period for such coverage is the earlier of the following:

1. the date on which You cease to be Totally Disabled;

2. three (3) months after the date on which insurance coverage would otherwise have terminated; or

3. the date on which You acquire insurance under a replacement plan which provides similar benefits but only if the plan covers the Injury or Sickness causing the disability without limitation.

If You are Hospital confined at the time insurance terminates, coverage will continue until Your Hospital confinement ends or benefits are exhausted, whichever is earlier.

G. MEDICARE ENROLLMENT

If You become enrolled in Medicare at the same time that Your coverage under the Group Policy is in force, continued coverage will be provided only to the extent that the benefits payable by the Group Policy are not also reimbursed by Your Medicare coverage. Your premium rate will be revised for this change in coverage as of the first premium due date after We receive written notice of Your Medicare enrollment.

If in the future, Public Law 104-191 is amended to allow termination of Your coverage upon enrollment in Medicare, We will have the option to take such action.

H. CANCELLATION BY THE INSURED

You may cancel Your coverage under the Group Policy by sending Us a written request. In this event, Your certificate will terminate on the first premium due date following the date We receive Your written request in Our Home Office, and Your coverage will not remain in effect during the grace period described in Part VIII of the Group Policy and certificate. Our liability for a premium refund will be limited to any premium payment We accept or draft from Your bank account in error after the date We receive Your written request to cancel Your coverage. You may not cancel Your coverage in advance of a premium due date to receive a refund of unearned premiums, unless otherwise allowed by the laws of Your state.

PART VII - GENERAL CONTRACT PROVISIONS

A. ENTIRE CONTRACT: The Group Policy (with the application, Your enrollment form, and all attached options and amendments) is the entire contract between the Group Policyholder, You and Us. Any statement made by You, in the absence of fraud, will be considered a representation and not a warranty. After Your certificate has been in force for two (2) consecutive years, any statements, except fraudulent misstatements, made in Your application will not be used to void the certificate. Any statement which You make for the purpose of effecting insurance may not be used to void Your coverage or reduce Your benefits unless it is contained in a written statement signed by You or the primary Insured, a copy of which has been furnished to You or Your beneficiary.

No changes in the Group Policy or the certificate shall be valid unless approved by an executive officer of the Company and such approval be endorsed thereon or attached thereto. No agent has the authority to change the Group Policy or the certificate or to waive any of their provisions.

B. INDIVIDUAL CERTIFICATES: A certificate will be issued to the Insured named in Schedule A of the certificate that describes the provisions of the Group Policy and where the Group Policy may be inspected.

C. CONFORMITY WITH STATE STATUTES: Any provisions of the certificate that are in conflict with the statutes of the state which governs this coverage will be changed or deemed to conform with the minimum requirements of such laws as of the time such laws should or would have been effective as to the certificate.

D. WAIVER OF RIGHTS: If any provision of the Group Policy or the certificate is not enforced, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Group Policy or the certificate.

E. OTHER INSURANCE WITH THIS INSURER: Insurance effective at any one time on You under a like group or individual policy in this Company is limited to the one such policy elected by You, Your beneficiary, or Your estate, as the case may be. All premiums paid on all other such policies from the time the duplication of coverage existed will be returned without interest.

PART VIII - PREMIUM PROVISIONS

A. GRACE PERIOD: After payment of the first premium, a grace period of thirty-one (31) days following a premium due date will be allowed to pay subsequent premiums. During the grace period, Your certificate will remain in force unless written notice is received from You prior to the end of the grace period that the coverage is to be terminated. If You do not pay the premium prior to the expiration of the thirty-one (31) day period from the due date, the certificate will lapse due to non-payment of premium and coverage will cease at 12:00 p.m. on the thirty-first (31st) day. You will be liable for payment of the premium for the period that the coverage remains in force if benefits are paid for Eligible Expenses incurred during the grace period. Such payment will not extend coverage beyond the grace period.

B. REINSTATEMENT: If Your certificate lapses due to non-payment of premium, reinstatement of Your coverage may be considered if You notify Us of Your intention to reinstate. Upon such notice, We will furnish You an application to be completed and submitted along with premiums necessary to pay the certificate to a current status. Your premium payment and Your completed application for reinstatement must be received at Our Home Office at the address shown on page 1 within ninety (90) days after the last day for which premium payment was made. Reinstatement will not be effective unless approved by the Company. At Our option, the approved reinstatement may not include coverage during the lapsed period and premiums would not be charged for this period.

C. MISSTATEMENT OF AGE OR SEX: If Your age or sex has been misstated, there shall be an adjustment of the premium for the certificate, retroactive to Your Effective Date, so that there shall be paid to Us the premium for the coverage at the correct age and sex. The amount of the insurance coverage shall not be affected. Continuation of coverage shall be contingent upon payment of all premium in arrears. Any overpayment of premium by You will be promptly refunded.

D. PREMIUM CHANGES: Your premium rate can be changed at any time by giving thirty-one (31) days written notice to You. Written notice shall be considered effective when We address the notice to Your last known mailing address and deposit the notice, postage paid, into the care and custody of the United States Postal Service. You cannot be singled out for renewal rate increases due to claim loss experience on Your individual certificate.

PART IX - CLAIM PROVISIONS

A. NOTICE OF CLAIM: Written notice of claim must be given to Us within thirty (30) days after the occurrence or commencement of any loss covered by the Group Policy, or as soon thereafter as is reasonably possible. Notice given by You or on Your behalf to Our Home Office with information sufficient to identify You, shall be deemed notice to Us.

B. CLAIM FORMS: When notice of claim is received, You will be sent forms for filing Your claim. If these forms are not given to You at Your last known address within fifteen (15) days, You can meet Our requirements by giving Us a written statement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the "Proof of Loss" provision. Where claims are incurred by a non-insuring parent of a child covered under the Group Policy, claim forms and any other necessary information will be provided for the non-insuring parent to obtain benefits.

C. PROOF OF LOSS: You must furnish Us acceptable written proof of loss within ninety (90) days of Your claim. If it was not possible for You to give proof within the ninety (90) days, Your claim will not be denied for this reason if You send the proof as soon as You can. In any event, You must send Us the proof no later than one (1) year from the time specified, unless You are legally incapacitated.

D. TIME OF PAYMENT OF CLAIMS: Payments for a covered claim will be made to You as they are incurred, within the time frames required by law in Your state of residence.

E. PAYMENT OF CLAIMS: All payments will be made to You, unless You direct otherwise in writing or except as provided herein. Any unpaid claim at Your death may, at Our option, be paid to Your beneficiary or estate. Where covered expenses are incurred by a non-insuring parent of a child that is covered under the Group Policy, benefits will be payable, as appropriate, to the non-insuring parent, a health care provider, or a state or federal agency when required by law.

F. PHYSICAL EXAMINATIONS AND AUTOPSY: We have a right to have You examined, at Our expense, as often as reasonably necessary while a claim is pending. In case of death, We may also have an autopsy performed unless prohibited by law.

G. CLAIMS APPEAL: If Your claim is denied in whole or in part, You will be notified in writing. Within sixty (60) days of receiving this notification, You may request that any portion of the claim for which You believe benefits were wrongly denied be reconsidered. Your request for reconsideration must be in writing, and must include:

1. the name and address of the Insured named in Schedule A of the certificate and the patient;

2. the Certificate Number;

3. the date(s) of service;

4. the claim number from the decline notice;

5. the provider's name; and

6. the reason why the claim should be reconsidered.

You may, within forty-five (45) days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. Written releases may be required, if it is determined that the information is sensitive or confidential. You may also, within forty-five (45) days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

A written decision will be provided to You within sixty (60) days after Your request for review has been received. That written decision will indicate the reasons for the decision and refer to the Group Policy provision(s) on which it was based. In special circumstances, additional time may be necessary to make a decision. You will be informed if this happens but it will never be more than one hundred twenty (120) days from the date of the original declination.

After You receive Our decision and if You disagree with the decision, You may request External Review as described in the following paragraph or arbitration as described in Part X of the Group Policy and certificate.

These claims appeal procedures also apply to any Utilization Review decision which is made as described in Part I of the Group Policy and certificate.

H. RIGHT TO EXTERNAL REVIEW: Within sixty (60) days after the date of receipt of a notice of an Adverse Determination or Final Adverse Determination, You may file a request for an external review with Us.

All requests for external review must be made in writing to National Health Insurance Company at 1901 N. State Highway 360, Grand Prairie, Texas 75050 or Post Office Box 619999, Dallas, Texas 75261-6199.

A request for an external review may not be made until You have exhausted Our Claims Appeal procedure.

An external review decision is binding on both You and Us except to the extent either of Us have other remedies available under applicable federal or state law.

Except in the case of a request for an expedited external review, at the time of filing a request for external review, You must submit to the independent review organization a filing fee of twenty-five dollars ($25.00) along with the information and documentation to be used by the independent review organization in conducting the external review. Upon application by You, the commissioner may waive the filing fee upon a showing of undue financial hardship. The filing fee will be refunded to the person who paid the fee if the external review results in the reversal, in whole or in part, of Our Adverse Determination or Final Adverse Determination that was the subject of the external review. If a request for a standard external review or an expedited external review is filed against Us, We will pay the cost of the independent review organization for conducting the external review and will not charge back the cost of the external review to a health care provider.

You have the right to contact the Commissioner of Insurance for assistance at any time by phoning (800) 224-6330, e-mailing Insurance.Administration@mail.state.ar.us, or writing to 1200 West Third Street, Little Rock, Arkansas 72201-1904.

When filing a request for an external review, You will be required to authorize the release of any of Your medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Notice related to an Adverse Determination: You may file a request for an expedited external review at the same time You file a request for an expedited review of an appeal as set forth in Our internal grievance procedure or utilization procedure if:

1. You have a medical condition where the timeframe for completion of an expedited review of an appeal set forth in Our internal grievance procedure or utilization review procedure would seriously jeopardize Your life or health or Your ability to regain maximum function; or

2. the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is "experimental" or

"investigational", and Your treating Physician certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

The independent review organization conducting the external review will determine whether You will be required to complete Our expedited internal grievance procedure or utilization review procedure before it conducts the expedited external review.

If You file an appeal under Our internal grievance procedure or utilization review procedure, and if We have not issued a written decision to You within thirty (30) days following the date You file the appeal with Us for a Pre-Certification claim or within sixty (60) days following the date You file the appeal with Us for a non-Pre-Certification claim, and You have not requested or agreed to the delay, You may file a request for external review and will be considered to have exhausted Our internal grievance procedure or utilization review procedure.

Notice related to a Final Adverse Determination: You may file a request for an expedited external review if:

1. You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function; or

2. if the Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which You received emergency services, but have not been discharged from the facility; or

3. a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, and Your treating Physician certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested health care service or treatment that is the subject of the requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

"Adverse Determination" means a determination by Us that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because the requested health care service does not meet Our requirements for medical necessity, or the requested health care services have been found to be "experimental/investigational".

In order to qualify as an "Adverse Determination" for purposes of external review, the decision must involve treatment, services, equipment, supplies, or drugs that would require Us to expend five hundred dollars ($500.00) or more.

"Adverse Determination" does not include a determination by Us to deny a health care service based upon:

1. an express exclusion in the health benefit plan other than a general exclusion for "medical necessity" or "experimental/investigational";

2. an express limitation in the health benefit plan with respect to the number of visits, treatments, supplies or services for a covered benefit in a given calendar period or over Your lifetime;

3. an express limitation in the health benefit plan with respect to a maximum dollar limitation with respect to a covered benefit in a given calendar period or over Your lifetime;

4. a determination by Us that You are not eligible to be a covered person;

5. a determination by Us that treatment, service, or supplies were requested or obtained by You through fraud or material misrepresentation;

6. the health benefit plan's procedure for determining Your access to a health care provider;

7. illegality of services or the means or methods of administering them;

8. FDA or other government agency determinations, reports, or statements; or

9. licensure, permit or accreditation status of a health care provider.

"Final Adverse Determination" means an Adverse Determination involving a covered benefit that has been upheld by Us at the completion of Our internal grievance procedure or utilization review procedure.

PART X - ARBITRATION OF CLAIM DISPUTES

Any dispute regarding claims processing or administration that has not been resolved after the procedures described in the "Claims Appeal" section of Part IX of the Group Policy and certificate have been followed, shall be resolved through non-binding arbitration. Such arbitration shall be administered under the rules of the American Arbitration Association (AAA). One (1) arbitrator shall decide the dispute, unless all parties agree to have three (3) arbitrators. Unless otherwise agreed by all parties, any arbitrator must be a licensed attorney who has practiced life, health and accident insurance law for at least five (5) years. Unless otherwise agreed by all parties, the arbitrator(s) shall be appointed from a list of qualified persons provided by AAA. Any court having proper jurisdiction over all parties may render judgment based upon the award of the arbitrator(s). All fees and expenses of the arbitration shall be paid by the parties equally, except that each party shall pay the cost of its own attorney, experts, witnesses and the preparation and presentation of its proof. The Federal Arbitration Act shall govern the arbitration. Such arbitration shall be a condition precedent to legal action by the Insured or the Company.

All aspects of the arbitration are confidential. Neither a party, an attorney for a party nor an arbitrator may disclose the evidence, content or results of the arbitration without the prior written consent of all parties.

PART XI - APPEAL AND ARBITRATION OF OTHER DISPUTES

Complaints and disputes other than those involving claims processing or administration will first be handled under the same general procedures as those set forth under Part IX of the Group Policy and certificate regarding "Claims Appeal". If this process does not resolve the complaint or dispute, then the matter will be resolved by non-binding arbitration under the same terms as provided under Part X of the Group Policy and certificate regarding "Arbitration of Claim Disputes".

PART XII - COORDINATION OF BENEFITS (COB)

A. COORDINATION OF BENEFITS: You may have other medical expense coverage in addition to this coverage. If so, the benefits from the "Other Plan" will be considered when Your claim is paid. This may require a reduction of benefits under this coverage so that the combined benefits will not be more than one hundred percent (100%) of Your "Allowable Expenses".

B. ORDER OF COORDINATION: To determine whether Our benefits will be reduced, the order in which the various plans will pay benefits has to be determined. This will be done as follows:

1. a plan with no provision to coordinate with other plans will be considered to pay its benefits before a plan which has such a provision;

2. a motor vehicle accident policy will be considered to pay its benefits before other plans for expenses incurred as a result of a motor vehicle accident;

3. a plan which covers You other than as a dependent will be considered to pay its benefits before a plan which covers You as a dependent;

4. a plan which covers You as a dependent of a person whose birthday occurs earlier in the year will be considered to pay its benefits before a plan which covers You as a dependent of a person whose birthday occurs later in the year; except in the case of separation or divorce, the following rules will apply:

    a. the plan of the parent with custody, who is not remarried, will be considered before the parent without custody;

    b. if the parent is remarried, and has custody of the child, the plan of the step-parent will be considered before the plan of the parent without custody;

    c. if there is a court decree which established financial responsibility for medical or health care expenses with respect to dependent children, the benefits of the plan of the parent with financial responsibility shall be considered before the benefits of any other plan;

5. the primary plan of a retired or laid-off employee who is covered by two (2) employers will be the plan which covers him/her as an active full-time employee; and

6. if 1, 2, 3, 4, or 5 above do not establish the order of payment, the plan under which You have been covered the longest will pay its benefits first. The date You first became a covered member of the group will be used as the oldest date of coverage.

C. OTHER PLAN: "Other Plan" means any other plan of medical expense coverage provided by:

1. group or blanket insurance coverage;

2. group Blue Cross, Blue Shield, other group prepayment coverage or health maintenance organization;

3. coverage under an employer sponsored self-insurance plan;

4. a motor vehicle insurance policy; and

5. coverage provided under any governmental program or required or provided by any statutes, except Medicaid or Medicare.

The term "Other Plan" will not include individual insurance or subscriber contracts, or group or blanket school accident type coverages, or hospital indemnity benefits.

D. ALLOWABLE EXPENSE: "Allowable Expense" means any usual or customary medical expense which is covered under any of the plans involved. An allowable charge to a "Secondary" plan includes the value or amount of any deductible, co-insurance percentage, or amount of

otherwise allowable expenses which were not paid by the "Primary" or first paying plan. Coordination of Benefits will not apply to claims of less than one hundred dollars ($100.00).

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION: Certain facts are needed to apply these COB rules. We may get material facts from each person claiming benefits and also gather material facts from or give them to any other insurance company or health benefit plan administrator with whom We coordinate benefits.

F. FACILITY OF PAYMENT: A payment made under another plan may include an amount which should have been paid under this plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again.

G. RIGHT TO RECOVERY: If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;

2. insurance companies; or

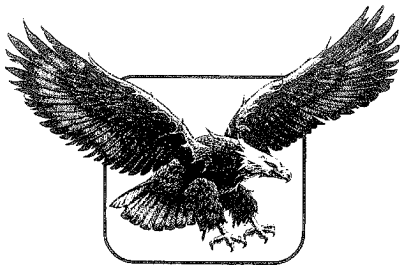
3. other organizations.

H. RIGHT OF SUBROGATION OR REIMBURSEMENT: Upon Our payment of any benefits under this coverage, We shall be subrogated to all of Your rights of recovery against any person or legal entity that may be liable to You, whether in contract or tort, for a claim arising out of or related to Your Injury or Sickness, but only to the extent of the benefits so provided. You shall cooperate with Us and do whatever is necessary for Us to secure Our subrogation rights and to collect Our subrogation claim. You shall not settle any such claim without Our consent or do anything to prejudice Our subrogation rights or Our efforts to collect Our subrogation claim.

As security for Your obligations to Us, You grant Us a lien on any sum of money that You may recover by settlement, judgment or otherwise, from any person or legal entity for a claim arising out of or related to Your Injury or Sickness. You agree that out of any such recovery, We shall receive the first disbursement for the amount of the benefits that We paid, regardless of whether You have been fully compensated and before payment of any other existing claims, including any claim by You for general damages. If any applicable law does not allow subrogation, You agree to reimburse Us from any such recovery for any benefits that We paid under this coverage, before applying the recovery to any other existing claim.

In the event You recover from the third party, reasonable cost of collection and attorney's fees thereof shall be assessed against You and Us in the proportion each benefits from the recovery.

GROUP HOSPITAL/SURGICAL/MEDICAL
CERTIFICATE OF COVERAGE
NATIONAL HEALTH INSURANCE COMPANY



P.O. Box 619999
Dallas, Tx 75261-6199

(Referred to in this Certificate as the Company, We, Us, Our)

This certificate is issued as evidence of coverage under the Group Policy for the Insured named in Schedule A and all covered Eligible Dependents. This certificate describes the benefits and other important provisions of the Group Policy. The Group Policy controls all the terms of the insurance coverage and may be inspected at the office of the Group Policyholder during regular business hours.

PLEASE READ THIS CERTIFICATE CAREFULLY.

Please review the copy of the application which is attached to this certificate. Write to Us at the address shown above if any information is not correct or complete. The application is a part of the insurance contract and an incorrect application may cause coverage to be voided or a claim to be reduced or denied.

To present inquiries, request information about the coverage, or to obtain assistance in resolving a complaint, contact Our Customer Service Department at [1-800-237-1900]. If a problem is not resolved, You may also write to the Department of Insurance in Your state.

IMPORTANT NOTICE: This insurance coverage contains requirements for Pre-Certification of Hospital confinements and outpatient surgery. Please refer to Part I of this Certificate for details. Benefit levels for most expenses vary between Network Providers and Non-Network Providers. Please refer to Parts II and III of this certificate for details.

RIGHT TO RETURN CERTIFICATE WITHIN TEN (10) DAYS: If for any reason You are not satisfied with this insurance certificate, You may return it to Us within ten (10) days after the date You receive it. If You return the certificate to Us within the ten (10) day period, the premium You paid will be promptly refunded and the certificate will be void as if it were never issued.

Signed at Our Home Office, Grand Prairie, Texas.

Secretary President

GROUP INSURANCE CERTIFICATE - NON-PARTICIPATING

COORDINATION OF BENEFITS INCLUDED - SEE PART XII

INDEX

SCHEDULE A

GROUP POLICYHOLDER:	[ABC ASSOCIATION]
NAME OF INSURED:	[John Doe]
NOTE:	COVERED ELIGIBLE DEPENDENTS, IF ANY, ARE NAMED IN THE APPLICATION ATTACHED HERETO.
ISSUE STATE:	[XX]
CERTIFICATE NUMBER:	[XXXXXXXXX]
GROUP POLICY NUMBER:	[HSMP-ABC]
EFFECTIVE DATE:	[August 1, 2009]
INITIAL TERM EXPIRES:	[September 1, 2009]
AGGREGATE AMOUNT MAXIMUM FOR EACH INJURY OR SICKNESS:	[$2,000,000]
LIFETIME MAXIMUM PER FAMILY:	[$10,000,000]
CALENDAR YEAR DEDUCTIBLE:	
IN-NETWORK	[$2,000 - $25,000]
OUT-OF-NETWORK	[$4,000 - $27,000]
BENEFIT PERCENTAGE:	
IN-NETWORK	[80%] [70%] [60%] [50%]
OUT-OF-NETWORK	[60%] [50%] [50%] [50%]
CO-INSURANCE PERCENTAGE:	
IN-NETWORK	[20%] [30%] [40%] [50%]
OUT-OF-NETWORK	[40%] [50%] [50%] [50%]
CO-INSURANCE MAXIMUM:	
IN-NETWORK	[$10,000]
OUT-OF-NETWORK	[$10,000 - $25,000]
ENHANCED OUTPATIENT MEDICAL BENEFIT DEDUCTIBLE:	
IN-NETWORK	[$1,000 - $10,000]
OUT-OF-NETWORK	[$2,000 - $11,000]
INITIAL PREMIUM:*	[$255.00]
RENEWAL PREMIUMS:* (SUBJECT TO CHANGE)	[$255.00]

* Premium amounts do not include administration fees or membership dues, if applicable.

This insurance is effective at 12:01 a.m. in the Issue State and on the Effective Date shown above and will continue according to the terms of the Group Policy if:

(1) the Insured is eligible for coverage under the Group Policy; and
(2) the required premiums have been paid.

NOTICE

Customer Service Department
National Health Insurance Company
Post Office Box 619999
Dallas, Texas 75261-6199
(800)237-1900

Agent's Name, Address, and Telephone Number:

Please see the bottom portion of page 4 of your application which is attached to the policy/certificate for the name of your agent. Call our toll-free number above if you should require the agent's address and/or telephone number.

If we at National Health Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact the Consumer Services Division of the Arkansas Department of Insurance at:

1200 West Third Street
Little Rock, Arkansas 72201-1904
(800) 852-5494 or (501) 371-2640
insurance.consumers@arkansas.gov

PART I - UTILIZATION SERVICES

Our UTILIZATION SERVICES Division provides a comprehensive, coordinated program that seeks to assure the highest quality medical care by combining Utilization Review, Second and Third Surgical Opinions, Pre-admission Testing and Case Management of catastrophic conditions.

FOR ALL UTILIZATION SERVICES, YOU OR YOUR PROVIDER MUST CALL [1-800-237-1900]. Emergency Hospital confinements that occur outside normal business hours must be reported within forty-eight (48) hours or on the first business day after admission.

A. UTILIZATION REVIEW

The goal of Our Utilization Review program is for You to receive necessary and appropriate treatment while avoiding unnecessary expenses when a Hospital confinement or outpatient surgical procedure is being considered. All review services are conducted by professional consultants such as registered nurses and social workers who have access to a panel of Physicians, advisors, and/or a Medical Director.

Utilization Review consists of the Pre-Certification of all non-emergency Hospital admissions or outpatient surgical procedures before services are provided, concurrent stay review, and discharge planning.

Utilization Review is not intended as a substitute for the medical judgment of an attending Physician or any other health care provider. However, if a particular treatment is not Pre-Certified when required, it will not be eligible for maximum benefits.

All Utilization Review decisions may be appealed as described in Part IX of the Group Policy and certificate regarding "Claims Appeal" and Part X regarding "Arbitration of Claim Disputes".

1. PRE-CERTIFICATION

   Pre-Certification does not guarantee that benefits will be paid. Payment of benefits will be determined by the Company in accordance with and subject to all of the terms, provisions, limitations, and exclusions of Your coverage under the Group Policy.

   Before You enter a Hospital on a non-emergency basis or schedule an outpatient surgical procedure, Our Utilization Services Division will, in conjunction with Your Physician, review the proposed treatment for medical necessity and appropriateness. A non-emergency Hospital confinement is one which can be scheduled in advance without endangering the health of the patient.

   The Pre-Certification process is set in motion by a telephone call from either You or Your provider to Our Utilization Services Division at the number specified within the second paragraph of this Part I section of the Group Policy and certificate. The following information is required:

   a. name, social security number, and address of the primary Insured;

   b. name of the Insured patient and relationship to the primary Insured;

   c. certificate or ID number;

   d. name and telephone number of the attending Physician;

e. name and address of the Hospital and the proposed date of admission; and

f. diagnosis and/or type of procedure (including outpatient surgery).

If a condition requires an emergency admission to a Hospital, You (or Your representative), the Hospital or the attending Physician must contact Our Utilization Services Division within forty-eight (48) hours or on the first business day after admission.

If the required Pre-Certification procedures are not followed, ELIGIBLE EXPENSES FOR ALL PROVIDERS WILL BE REDUCED BY THIRTY PERCENT (30%). For each Hospital confinement, Our personnel will determine the number of days of confinement which will be authorized for payment. If charges are incurred for days of confinement that were not authorized, NO BENEFITS WILL BE PAYABLE FOR THE UNAUTHORIZED DAYS.

Pre-Certification is valid for thirty (30) days after the confinement or surgical procedure is authorized. If the treatment does not occur as planned, You or the provider must contact Us again to renew the Pre-Certification. If this renewal procedure is not followed, ELIGIBLE EXPENSES FOR ALL PROVIDERS WILL BE REDUCED BY THIRTY PERCENT (30%).

Pre-Certification is not required for Hospital admissions for maternity that do not exceed forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean section, excluding the date of delivery. Maternity stays in excess of these maximums must be requested by Your attending Physician. NO BENEFITS WILL BE PAID FOR EXCESS UNAUTHORIZED DAYS.

2. CONCURRENT STAY REVIEW AND DISCHARGE PLANNING

Our Utilization Services Division will monitor Your Hospital stay and coordinate with Your attending Physician, and the Hospital, either Your scheduled release from the Hospital or an extension of the Hospital admission. If Your attending Physician feels it is Medically Necessary for You to remain in the Hospital for a greater length of time than originally authorized, the attending Physician must request the additional days prior to the end of the Pre-Authorized confinement. NO BENEFITS WILL BE PAYABLE FOR UNAUTHORIZED DAYS.

B. SECOND AND THIRD SURGICAL OPINIONS

Some surgical procedures are performed unnecessarily or inappropriately. In many instances, surgery is only one of several treatment options. In other situations, surgery will not be of any benefit to the patient. In some cases, surgery can be performed on an outpatient basis.

As medical practices change, specific surgical procedures requiring an additional opinion will also change. Our Utilization Services Division will determine whether a second surgical opinion will be required. For those procedures requiring additional opinions, the additional consultations must be with Physicians who are board certified specialists in the area involved and must not have any financial association with the surgeon recommending the surgery.

If a second surgical opinion does not confirm the need for surgery, then a third opinion will be required. If the third opinion does not confirm the necessity for surgery, all Eligible Expenses will be paid if You desire the procedure, subject to all other terms of the coverage provided under the Group Policy. Second and third consultations will be considered as Eligible Expenses and will not be subject to the Calendar Year Deductible or Co-Insurance requirements.

FAILURE TO OBTAIN REQUIRED ADDITIONAL OPINIONS WILL RESULT IN A THIRTY PERCENT (30%) REDUCTION IN THE ELIGIBLE EXPENSES FOR THE SURGICAL PROCEDURE.

C. ROUTINE PRE-ADMISSION TESTING

Benefits will be payable for a covered Injury or Sickness for routine pre-admission laboratory tests and x-ray examinations when performed on an outpatient basis within seven (7) days prior to a Hospital admission, subject to satisfaction of the Calendar Year Deductible and Co-Insurance requirements. The procedures must be required by the condition causing the Hospital confinement and must be performed in place of the same tests and examinations that would otherwise be conducted during the Hospital confinement. Charges incurred will be considered as Eligible Expenses even if the results reveal that the condition requires medical treatment prior to Hospital admission or that the Hospital admission is not required.

D. CASE MANAGEMENT OF CATASTROPHIC CONDITIONS

When a catastrophic Sickness or Injury requires long term care, after being stabilized in a Hospital, You can possibly be discharged from the Hospital into a more cost effective care setting while still maintaining a high quality level of care. The Case Management program is designed for those situations which involve a large cash outlay for expenses that ordinarily would not be covered under the Group Policy.

Case Management is utilized only when:

1. the catastrophic Sickness or Injury occurs while both You and Your Sickness or Injury are covered under the Group Policy;

2. You have been hospitalized and Your attending Physician determines that the condition is stabilized;

3. You continue to require that Your care be managed but You need not be hospitalized to receive the care;

4. Your placement in a new care setting is contemplated, entailing costs which are not ordinarily reimbursable under the Group Policy; and

5. the Company, the Case Manager, Your attending Physician, and Your legal representative agree to the alternate treatment plan.

The Case Manager will coordinate and implement Your Case Management program and will provide information on resources and suggestions for proper treatment plans. Once an agreement has been reached, the Group Policy will reimburse for all expenses incurred, even if those expenses would normally not be considered as Eligible Expenses, subject to the Aggregate Amount Maximum and the Lifetime Maximum amount.

Case Management is a voluntary service with no reduction of benefits or other penalties attached if You choose not to participate.

PART II - BENEFIT LEVELS

The Company accesses Preferred Provider Networks consisting of Hospitals, Physicians, and other specialty types of health care providers and facilities in which the participating providers (hereafter called "Network Providers") have agreed to provide services at a discounted rate to the Company's Insureds. Benefits will be based on Your choice of a health care provider. You will

choose whether to use a Network Provider at the time that services are needed. There is no requirement to commit in advance to utilizing a Network Provider.

A Network Provider Directory will be made available to You which will list all Network Providers in Your general geographic area. The Company will periodically update this information, but since Network Providers can change, You should call [1-800-237-1900] or visit our website at [www.nhic.com] to make sure that the provider is still a Network Provider before You receive medical services.

The following provisions apply to all benefits provided by the Group Policy with the exception of the Enhanced Outpatient Medical Benefit.

A. CALENDAR YEAR DEDUCTIBLES

IN-NETWORK: The In-Network Calendar Year Deductible amount is shown in Schedule A of the certificate. You can meet this Deductible by incurring Eligible Expenses for services received from either Network or Non-Network Providers.

After three (3) individual In-Network Calendar Year Deductibles have been satisfied by any three (3) Insureds within a family, additional In-Network Calendar Year Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

OUT-OF-NETWORK: The Out-of-Network Calendar Year Deductible amount is shown in Schedule A of the certificate. You can meet this Deductible by incurring Eligible Expenses only from Non-Network Providers.

After three (3) individual Out-of-Network Calendar Year Deductibles have been satisfied by any three (3) Insureds within a family, additional Out-of-Network Calendar Year Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

B. BENEFIT AND CO-INSURANCE PERCENTAGES

After satisfaction of the Calendar Year Deductible requirement(s), Eligible Expenses will be paid at the Benefit Percentage shown in Schedule A of the certificate for either In-Network or Out-of-Network services, based on Your choice of provider. You will be responsible for the Co-Insurance percentage shown in Schedule A of the certificate for either In-Network or Out-of-Network services, based on Your choice of provider.

C. CO-INSURANCE MAXIMUMS

The Co-Insurance Maximum amounts are shown in Schedule A of the certificate. There is an In-Network Co-Insurance Maximum amount and an Out-of-Network Co-Insurance Maximum amount. You can meet both these amounts simultaneously with Eligible Expenses incurred for services received from either a Network or a Non-Network Provider, up to the amount of the In-Network Co-Insurance Maximum. After the In-Network Co-Insurance Maximum amount has been satisfied, only Eligible Expenses incurred for services received from a Non-Network Provider can be used to satisfy any remaining Out-of-Network Co-Insurance Maximum amount.

After You meet the In-Network Deductible and In-Network Co-Insurance Maximum amount, additional Eligible Expenses incurred during that same Calendar Year, for services received from a Network Provider, will not be subject to Co-Insurance.

After You meet the Out-of-Network Deductible and Out-of-Network Co-Insurance Maximum amount, additional Eligible Expenses incurred during that same Calendar Year, for services received from a Non-Network Provider, will not be subject to Co-Insurance.

Co-Insurance Maximum amounts apply to each Insured each Calendar Year even though a condition or claim may continue from one (1) Calendar Year to the next. After three (3) Insureds within a family have met the In-Network Co-Insurance Maximum amount in a Calendar Year, additional Eligible Expenses of any Insured within the same family will not be subject to Co-Insurance for the remainder of that same Calendar Year.

This provision applies to all benefits where there is a differential between the amounts payable for services received from Network versus Non-Network Providers:

D. MEDICAL EMERGENCY SERVICES

If You cannot reasonably access a Network Provider, the following emergency care services will be reimbursed at the Network Provider level of benefits until You can reasonably be expected to transfer to a Network Provider:

1. a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital that is necessary to determine whether a Medical Emergency condition exists;

2. necessary emergency care services, including the treatment and stabilization of a Medical Emergency condition; and

3. services originating in a Hospital emergency facility following treatment or stabilization of a Medical Emergency condition.

PART III - ELIGIBLE EXPENSES

Subject to the provisions set forth in this section and all other terms of the Group Policy, charges for the services described in the following paragraphs will qualify as Eligible Expenses and will be considered for payment. All benefits payable are subject to the Aggregate Amount Maximum of [two million dollars ($2,000,000.00)] per Injury or Sickness and a Lifetime Maximum amount of [ten million dollars ($10,000,000.00)] for all combined claim payments for all Insureds.

Eligible Expenses must meet the following requirements in order to be considered for payment:

1. any Injury is sustained or first occurs on or after the Effective Date of Your coverage under the Group Policy and while Your coverage is in force;

2. any Sickness first Manifests itself after the Effective Date of Your coverage under the Group Policy and while Your coverage is in force;

3. the Eligible Expense is incurred while Your coverage under the Group Policy is in force; and

4. any loss for any Pre-Existing Condition, which is not excluded by endorsement or by name or specific description, occurs after You have been covered for twenty-four (24) months under the Group Policy.

A. INPATIENT HOSPITAL EXPENSES

If You receive treatment in a Hospital on an inpatient basis for a covered Injury or Sickness, Eligible Expenses under this benefit will be the Usual and Customary Charges for Hospital expenses incurred in the course of Your treatment, excluding:

1. ambulance charges (covered under separate benefit paragraph);

2. charges for Hospital room and board in excess of the Hospital's most prevalent semi-private room rate (except for Intensive Care Unit charges);

3. charges for personal, comfort, or convenience items such as telephone, television, or radio;

4. take home items, including but not limited to drugs and medicines;

5. charges for any other items or services which are not Medically Necessary; and

6. charges for any days of confinement not authorized in the Pre-Certification or Concurrent Stay Review process.

B. INPATIENT MEDICAL EXPENSES

If You receive treatment in a Hospital on an inpatient basis for a covered Injury or Sickness, Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for the items of medical expense listed herein. The eligible items of expense are:

1. Surgeons' fees for surgical operations;

2. Assistant Surgeons' fees for surgical operations;

3. Anesthesiologists' fees;

4. Physicians' Visits at Hospital (not payable to surgeon or assistant surgeon);

5. Pathologists' fees;

6. Radiologists' fees; and

7. Physiotherapists' fees.

C. OUTPATIENT SURGICAL EXPENSES

If You have a surgical operation that is performed on an outpatient basis in a Physician's office or clinic, Hospital, or ambulatory surgery facility due to a covered Injury or Sickness, the Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for the items of expense listed herein. The eligible items of expense are:

1. Hospital or ambulatory surgery facility fees;

2. Surgeons' fees for surgical operations;

3. Assistant Surgeons' fees for surgical operations;

4. Anesthesiologists' fees;

5. Pathologists' fees; and

6. Radiologists' fees.

D. WELL CHILD CARE

If You incur expenses for preventive and primary care services provided by a Physician or under the supervision of a Physician during unlimited visits for Eligible Dependent children up to the

age of twelve (12) and during three (3) visits per Calendar Year for children ages twelve (12) to twenty-one (21), Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for such services. Preventive and primary care services shall include physical examinations, measurements, sensory screening, neuropsychiatric evaluation, developmental screening and anticipatory guidance. Eligible Expenses will also include hereditary and metabolic screening at birth, urinalysis, tuberculin tests and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy, hypothyroidism, phenylketonuria (PKU), galactosemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas. The Usual and Customary Charges for immunization services, without application of the Calendar Year Deductible or Co-Insurance, will also be considered as Eligible Expenses under this benefit.

In addition, Eligible Expenses under this benefit include the Usual and Customary Charges incurred for routine Hospital nursery care and pediatric charges for a child born to the Insured named in Schedule A of the certificate on or after the Effective Date of the certificate. Benefits will be payable for up to five (5) full days in a Hospital nursery or until the parent is discharged from the Hospital following the birth of the child, whichever is the lesser period of time. Eligible Expenses for the child will be subject to the Calendar Year Deductible and Co-Insurance for the child.

E. DIABETES SERVICES

If You have been diagnosed with insulin-dependent, insulin-using, gestational, or non-insulin using diabetes or elevated blood glucose levels resulting from another medical condition, Eligible Expenses under this benefit will be the Usual and Customary Charges for Medically Necessary equipment, supplies, and services which are provided or prescribed by a Physician in the course of Your treatment.

Eligible Expenses will also include the Usual and Customary Charges for outpatient self-management training and education, including medical nutritional therapy when prescribed by Your Physician.

F. HOME HEALTH CARE

If You incur expenses for Home Health Care, such expenses will qualify as Eligible Expenses if:

1. expenses are incurred beginning within fourteen (14) days after being discharged from a Hospital where treatment was received for a covered Injury or Sickness;

2. Your Physician certifies that without Home Health Care, You would have to remain Hospital confined to receive proper treatment;

3. You continue to need care and treatment in Your place of residence; and

4. Your Physician submits a Home Health Care plan in writing to the Company.

Eligible Expenses under this benefit will be the Usual and Customary Charges for Home Health Care for the following services, to a maximum of [twenty thousand dollars ($20,000.00)] per Calendar Year per Insured.

Skilled Nursing Care
Physical Therapy
Occupational Therapy
Medical/Social Work
Nutritional Services
Respiratory Therapy
Speech Therapy
Medical Appliances and Equipment
Prescription Drugs
Laboratory Services
Home Health Aid Visits

Home Health Care does not include and no benefits will be payable for custodial care or services or supplies not included in the Home Health Care plan submitted by Your Physician.

The Company's Case Management Services will be available to You and Your family. There is no reduction of benefits or other penalties attached if You choose not to utilize these services.

G. HOSPICE CARE

If You should require Hospice Care for a covered Injury or Sickness, Eligible Expenses under this benefit will be the Usual and Customary Charges for Hospice Care to a lifetime maximum per Insured of the lesser of one hundred eighty (180) days or [ten thousand dollars ($10,000.00)], if:

1. Your Physician certifies that Your life expectancy is less than six (6) months;

2. Your Physician recommends a Hospice Care program for Your benefit and that of Your immediate family;

3. the services and supplies are ordered by a Physician who directs the Hospice Care program; and

4. the services and supplies are provided to reduce or abate pain or other symptoms of distress and to meet the stresses of dying.

The Company's Case Management Services will be available to You and Your family. There is no reduction of benefits or other penalties attached if You choose not to utilize these services.

H. AMBULANCE

If You require transportation by ambulance for treatment of a covered Injury or Sickness, Eligible Expenses under this benefit will be such ambulance transportation expenses to a maximum of [five hundred dollars ($500.00)] per Insured per Calendar Year.

I. WOMEN'S HEALTH AND CANCER RIGHTS

The United States Congress passed legislation effective October 21, 1998 which requires individual and group health plans to provide reconstructive surgery benefits if the plan normally provides medical and surgical benefits for a mastectomy. The required coverage consists of:

1. reconstruction of the breast on which the mastectomy was performed; and

2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. prostheses and physical complications from all stages of a mastectomy including lymphedemas.

These benefits must be provided in a manner determined in consultation with the attending provider and the patient. The coverage will be subject to the same Deductible, Co-Insurance, and other benefit provisions as for similar types of expenses covered under the plan for other Sicknesses. These benefits will not duplicate any other benefits payable under the plan. Coverage provided will be in accordance with federal and state law and applicable regulations.

J. ENHANCED OUTPATIENT MEDICAL BENEFIT

This paragraph is NOT SUBJECT to the Calendar Year Deductibles, Benefit Percentages, Co-Insurance Percentages, or Co-Insurance Maximums shown in Schedule A of the certificate. Separate Deductible amounts, benefit percentages, and co-insurance maximum apply to this paragraph. Eligible Expenses incurred under this benefit may not be used to

satisfy the Calendar Year Deductibles or Co-Insurance Maximums shown in Schedule A of the certificate.

The Enhanced Outpatient Medical Benefit Deductible amounts are shown in Schedule A of the certificate and apply to each Insured each Calendar Year. There is an In-Network Deductible amount and an Out-of-Network Deductible amount. These Deductible amounts may be satisfied only with Eligible Expenses incurred under the Enhanced Outpatient Medical Benefit.

You can meet the In-Network Enhanced Outpatient Medical Benefit Deductible amount by incurring Eligible Expenses for services received from either Network or Non-Network Providers. After three (3) total In-Network Deductibles have been satisfied by any three (3) Insureds within a family, additional In-Network Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

You can meet the Out-of-Network Enhanced Outpatient Medical Benefit Deductible amount by incurring Eligible Expenses only from Non-Network Providers. After three (3) total Out-of-Network Deductibles have been satisfied by any three (3) Insureds within a family, additional Out-of-Network Deductibles will not be taken from the Eligible Expenses of any Insured within the same family during that same Calendar Year.

Eligible Expenses are the Usual and Customary Charges incurred for THE FOLLOWING outpatient services/treatments which You receive in a Physician's office or clinic, Hospital, or ambulatory surgery facility due to a covered Injury or Sickness. After the Deductible requirement(s) have been met from Eligible Expenses, benefits will be paid at [eighty percent (80%)] of Usual and Customary Charges for services received from a Network Provider or [sixty percent (60%)] of Usual and Customary Charges for services received from a Non-Network Provider for the next [ten thousand dollars ($10,000)] of Eligible Expenses. Thereafter, during that same Calendar Year, Eligible Expenses will be paid at [one hundred percent (100%)] of Usual and Customary Charges. You are responsible for the Deductible requirement(s), Your portion of Eligible Expenses incurred after the Deductible is satisfied, and any non-covered charges. These benefit payment provisions apply to the expenses incurred for each Insured individually.

Pathology (Lab. Services)
Radiology (X-Rays)
Upper/Lower G.I. Series
CAT Scans
Magnetic Resonance Imaging
Nerve Conduction Studies
Emergency Room Facility Fees
Non-Surgical Anesthesia
Casts, Splints & Braces
Surgical Dressings
Central Supplies
Kidney Dialysis
Chemotherapy Treatments
Cobalt Treatments
Irradiation Treatments
Ultrasound
Sonograms
Myelograms
Pyelograms
Angiograms
Electrocardiograms
Electroencephalograms
Electromyograms
Pneumoencephalograms
Durable Medical Equipment - Maximum of $2,500 per Insured per Calendar Year.
Physical Therapy - Not to exceed the lesser of 25 treatments or $2,000 per Insured per Calendar Year.
Occupational Therapy - Not to exceed the lesser of 25 treatments or $2,000 per Insured per Calendar Year.

Total benefits provided will be **LIMITED TO THOSE SERVICES LISTED ABOVE** and shall not exceed [two hundred fifty thousand dollars ($250,000.00)] of Eligible Expenses per Insured per Calendar Year. Kidney dialysis must be received in a Medicare approved dialysis center. This benefit does not provide coverage for Physician fees (including but not limited to Physician fees for office or clinic visits, routine physical exams, or surgery), prescription drugs or any other service not specifically listed.

K. MAMMOGRAPHY AND CYTOLOGIC SCREENING

This benefit is NOT SUBJECT to satisfaction of the Calendar Year Deductibles or Co-Insurance.

If You receive any of the following services, Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for such services. The eligible services are:

1. an annual cervical cytologic screening for a female Insured;

2. any cervical cytologic screening for a female Insured which her Physician certifies to be Medically Necessary;

3. a baseline mammogram and annual mammograms thereafter for a female Insured; and

4. any mammogram for a female Insured which is certified to be Medically Necessary by her Physician or which is recommended by her Physician where such Insured or her mother or sister has had a history of breast cancer.

Eligible Expenses for cervical cytologic screening include only the laboratory charges for the test and do not include the Physician office visit charge.

L. PROSTATE CANCER SCREENING

This benefit is NOT SUBJECT to satisfaction of the Calendar Year Deductibles.

Eligible Expenses under this benefit will be the Usual and Customary Charge for prostate cancer screening performed by a Physician in accordance with the National Comprehensive Cancer Network guidelines in effect as of January 1, 2009 for the ages, family histories, and frequencies referenced in such guidelines. If a Physician recommends that You undergo a prostate specific antigen blood test, We may not deny coverage for the test on the basis of a previous negative digital rectal examination.

M. TREATMENT OF CATASTROPHIC METABOLIC DISORDERS

If You have been diagnosed with a Catastrophic Metabolic Disorder, Eligible Expenses under this benefit will be charges incurred for Medically Necessary amino acid modified preparations, Medical Foods, Low Protein Modified Food Products and any other special dietary products and formulas prescribed and administered by a Physician for the therapeutic treatment of Catastrophic Metabolic Disorders which are in excess of two thousand four hundred dollars ($2,400.00) in a Calendar Year.

"Catastrophic Metabolic Disorder" means phenylketonuria (PKU), galactosemia, organic acidemias, and disorders of amino acid metabolism.

"Inherited Metabolic Disease" means a disease caused by an inherited abnormality of body chemistry.

"Low Protein Modified Food Product" means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease.

"Medical Food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

N. MUSCULOSKELETAL DISORDERS OF THE FACE, NECK OR HEAD

Eligible Expenses under this benefit are the Usual and Customary Charges incurred for surgical or nonsurgical medical treatment of a musculoskeletal disorder affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder. Coverage will be provided for Medically Necessary diagnosis and treatment of these conditions regardless of cause and whether prescribed or administered by a dentist or a Physician. Benefits will be payable only to the same extent as for any other Sickness covered under the Group Policy.

O. COLORECTAL CANCER SCREENING

Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for Colorectal Cancer Screening for Insureds who are:

1. fifty (50) years of age or older;

2. less than fifty (50) years of age but who are at High Risk for Colorectal Cancer; or

3. Symptomatic of Colorectal Cancer as determined by a Physician.

Benefits for Colorectal Cancer Screening services will include an examination of the entire colon including the following examinations and laboratory tests:

1. an annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;

2. a double-contrast barium enema every five (5) years; or

3. a colonoscopy every ten (10) years.

The Insured will determine the choice of screening strategies in consultation with a Physician. Benefits will also include any additional medically recognized screening tests for colorectal cancer required by the Director of the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations.

This benefit will also include coverage for follow-up screenings based on the following guidelines:

1. if an initial colonoscopy was normal, a follow-up screening after ten (10) years;

2. if the Insured had one (1) or more neoplastic polyps or adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, a follow-up screening after three (3) years;

3. if the Insured had a single tubular adenoma of less than one centimeter (1 cm), a follow-up screening after five (5) years; or

4. if the Insured had large sessile adenomas greater than three centimeters (3 cm), especially if removed in a piecemeal fashion, a follow-up screening in six (6) months or until complete polyp removal is verified by colonoscopy.

"High Risk for Colorectal Cancer" means:

1. the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy;

2. a family history of colorectal cancer in close relatives such as parents, brothers, sisters, or children;

3. genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis;

4. a personal history of colorectal cancer, ulcerative colitis, or Crohn's disease;

5. the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; or

6. any additional or expanded definition of "High Risk for Colon Cancer" as recognized by medical science and determined by the Director of the Division of Health of the Department of Health and Human Services in consultation with the University of Arkansas for Medical Sciences.

"Symptomatic of Colorectal Cancer" includes:

1. bleeding from the rectum or blood in the stool; or

2. a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

P. SPEECH OR HEARING IMPAIRMENT

Eligible Expenses under this benefit will be the Usual and Customary Charges incurred for the necessary care and treatment of loss or impairment of speech or hearing. "Loss or Impairment of Speech or Hearing" shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of the provider's area of certification.

This benefit will include coverage for a hearing aid purchased from a professional licensed in the state of Arkansas to dispense a hearing aid. The maximum benefit amount payable for a hearing aid is one thousand four hundred dollars ($1,400.00) per ear in a three year period and is not subject to Deductible or Co-Insurance requirements.

"Hearing aid" means an instrument or device, including repair and replacement parts, that:

1. is designed and offered for the purpose of aiding persons with or compensating for impaired hearing;

2. is worn in or on the body; and

3. is generally not useful to a person in the absence of a hearing impairment.

Q. ORTHOTIC DEVICES/SERVICES AND PROSTHETIC DEVICES/SERVICES

Eligible Expenses under this benefit will be eighty percent (80%) of Medicare allowable charges as defined by the Center for Medicare and Medicaid Services Healthcare Common Procedure Coding System as of January 1, 2009 or as later revised, for the following Medically Necessary items prescribed and provided by a Physician:

1. an Orthotic Device;

2. an Orthotic Service;

3. a Prosthetic Device; and

4. a Prosthetic Service.

This benefit will include Medically Necessary replacement once every three (3) years unless more frequent replacement is Medically Necessary. Coverage will include replacement or repair necessitated by anatomical change or normal use of an Orthotic or Prosthetic Device unless the repair or replacement is due to misuse or loss. If We deny or limit coverage under this benefit based on lack of Medical Necessity, External Review is available to You as described in Part IX.H. of the Group Policy and certificate.

"Orthotic Device" means an external device that is intended to restore physiological function or cosmesis to a patient and is custom made, fitted, or adjusted for the patient. Orthotic Device does not include a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that is carried in stock by the seller and sold without therapeutic modification and has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

"Orthotic Service" means the evaluation and treatment of a condition that requires the use of an Orthotic Device.

"Prosthetic Device" means an external device that is intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and that is custom made, fitted, or adjusted for the patient. Prosthetic Device does not include an artificial eye, a dental appliance, a cosmetic device such as eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

"Prosthetic Service" means the evaluation and treatment of a condition that requires the use of a Prosthetic Device.

PART IV - EXCLUSIONS AND LIMITATIONS

No payment will be made for claims resulting in or from:

1. a Pre-Existing Condition, which is not excluded by endorsement or by name or specific description, unless the expense is incurred after You have been covered for more than twenty-four (24) months under the Group Policy, excluding newborns and adoptees as provided in Part VI of the Group Policy and certificate;

2. any Injury that was sustained prior to Your Effective Date of coverage under the Group Policy;

3. normal childbirth;

4. prenatal care;

5. Mental or Emotional Disorders, unless specifically provided in the Group Policy due to state mandates and described in the certificate;

6. treatment for alcohol or chemical substance use, abuse, or dependency or illegal drug use or experimentation, unless specifically provided in the Group Policy due to state mandates and described in the certificate;

7. any loss incurred where a contributing factor to the loss was You being Intoxicated or under the influence of any substance which has the capacity to disturb Your mental, emotional, or physical faculties, unless administered on the advice of a Physician;

8. any expenses which exceed the Usual and Customary Charges;

9. any expenses incurred which are not Medically Necessary;

10. aviation (while acting as a pilot or crew member);

11. war or act of war (declared or undeclared);

12. participation in a felony, riot or insurrection;

13. service in the armed forces or units auxiliary thereto (upon notice of Your entry into the armed forces or units auxiliary thereto, You will receive a partial refund of unearned premiums, if any);

14. suicide or intentionally self-inflicted harm;

15. cosmetic surgery, except that surgery resulting from a covered Injury or covered Sickness and reconstructive surgery because of congenital disease or anomaly which has resulted in a functional defect of an Eligible Dependent child born to or placed for adoption with the Insured named in Schedule A of the certificate on or after its Effective Date;

16. breast reduction or augmentation even if Medically Necessary, unless due to reconstructive surgery which is needed as a result of a mastectomy performed due to a diagnosis of breast cancer;

17. dental care or treatment, except that dental treatment caused by an Accidental Injury;

18. weight loss procedures even if Medically Necessary;

19. voluntary abortions, sterilization procedures, or reversals of sterilization procedures;

20. penile implants even if Medically Necessary;

21. sex transformation procedures, hormones for such treatment and charges for related psychiatric care or counseling;

22. infertility treatment including but not limited to artificial insemination, in vitro fertilization, or embryo transfer procedures;

23. experimental treatment or experimental surgery not recognized by the American Medical Association, or considered to be experimental or investigational by any appropriate health care technological assessment body established by a state or federal government;

24. Radial Keratotomy or similar procedures to improve vision, eyeglasses, contact lenses, and examination for the prescription or fitting thereof;

25. any loss covered by worker's compensation, employer's liability benefits, or occupational disease law;

26. services performed by a member of Your family, services for which no charge is normally made in the absence of insurance, or services of a federal, veterans', state or municipal Hospital (unless You are financially responsible for the charges);

27. any expenses paid for under another part of the Group Policy;

28. legal expenses, whether or not incurred to obtain medical treatment;

29. any expense for which Medicare benefits are payable (benefits will not be reduced or denied because the medical expense was covered by the Medical Assistance Act of 1967, better known as Medicaid);

30. routine physical examinations for adult Insureds unless specifically provided in the Group Policy due to state mandates and described in the certificate; and

31. any item not specifically listed in the Group Policy and certificate as a benefit.

PART V - DEFINITIONS

A. "ACCIDENT/ACCIDENTAL" means any sudden or unforeseen event which results in accidental bodily Injury sustained by an Insured which is the direct cause, independent of disease or bodily infirmity or any other cause, and occurs while the Insured's coverage under the Group Policy is in force.

B. "AGGREGATE AMOUNT MAXIMUM" means the maximum amount of Eligible Expenses that will be covered under the Group Policy for each Injury or Sickness with respect to each Insured. The Aggregate Amount Maximum is shown in Schedule A.

C. "ASSOCIATION" means the Group Policyholder as shown in Schedule A.

D. "CALENDAR YEAR" means the period beginning January 1 of any year and ending December 31 of the same year.

E. "CO-INSURANCE" means the percentage of Eligible Expenses that are to be paid by You based on Your choice of Provider, after satisfaction of the Calendar Year Deductible requirements. The Co-Insurance Percentages are shown in Schedule A of the certificate unless specified otherwise in the benefit description.

F. "CO-INSURANCE MAXIMUM" means the total amount of Eligible Expenses that each Insured is required to incur each Calendar Year, after satisfaction of the Calendar Year Deductible requirements, before the Group Policy will pay one hundred percent (100%) of all additional Eligible Expenses incurred for that Insured during that Calendar Year.

The Co-Insurance Maximum amounts are shown in Schedule A of the certificate. There is an In-Network Co-Insurance Maximum amount and an Out-of-Network Co-Insurance Maximum amount. Eligible Expenses which are not subject to payment of Co-Insurance cannot be used to satisfy the Co-Insurance Maximums.

Co-Insurance Maximum amounts apply to each Insured each Calendar Year even though a condition or claim may continue from one (1) Calendar Year to the next. After three (3) Insureds within a family have met the In-Network Co-Insurance Maximum amount in a Calendar Year, additional Eligible Expenses of any Insured within the same family will not be subject to Co-Insurance for the remainder of that same Calendar Year.

G. "COMPLICATIONS OF PREGNANCY" means:

1. Hospital confinement required to treat conditions, such as the following, in a pregnant female: acute nephritis; nephrosis; cardiac decompensation; HELLP syndrome; uterine rupture; amniotic fluid embolism; chorioamnionitis; fatty liver in pregnancy; septic abortion; placenta accreta; gestational hypertension; puerperal sepsis; peripartum cardiomyopathy; cholestasis in pregnancy; thrombocytopenia in pregnancy; placenta previa; placental abruption; acute cholecystitis and pancreatitis in pregnancy; postpartum hemorrhage; septic pelvic thromboplebitis; retained placenta; venous air embolus associated with pregnancy; miscarriage; or an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of

descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section.

2. Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism; hepatitis B or C; HIV; Human papilloma virus; abnormal PAP; syphilis; Chlamydia; herpes; urinary tract infections; thromboembolism; appendicitis; hypothyroidism; pulmonary embolism; sickle cell disease; tuberculosis; migraine headaches; depression; acute myocarditis; asthma; maternal cytomegalovirus; urolithiasis; DVT prophylaxis; ovarian dermoid tumors; biliary atresia and/or cirrhosis; first trimester adnexal mass; hyditidiform mole; or ectopic pregnancy.

H. "DEDUCTIBLE" means the amount of Eligible Expenses for which no benefits are payable in any one Calendar Year. The Calendar Year Deductibles are based on Your choice of provider and are shown on the Schedule A page of the certificate. The Deductible is Your sole responsibility and must be satisfied by incurring charges which are Eligible Expenses under the terms of the Group Policy, excluding those Eligible Expenses that are not subject to the Calendar Year Deductible. Part II.A. of the Group Policy and the certificate sets forth the Deductible requirements.

If two (2) or more Insureds in the same family are injured in the same Accident, only one (1) Deductible and one (1) Co-Insurance Maximum amount will be required during that Calendar Year for all Eligible Expenses resulting from Injuries sustained in the Accident.

Certain benefits under the Group Policy may not be subject to the Calendar Year Deductibles shown in Schedule A of the certificate. These benefits may instead be subject to a separate Deductible for that particular benefit. These types of provisions are set forth in the description for the particular benefit.

I. "EFFECTIVE DATE" means the date shown in Schedule A of the certificate on which coverage begins for Insureds who were listed on the original application and for whom issuance of coverage was approved. The Effective Date of coverage for an Insured who is added at a later date will be shown on an endorsement which will be issued by the Company to provide evidence of the addition.

J. "ELIGIBLE DEPENDENT(S)" means:

1. the legal spouse of the Insured named in Schedule A of the certificate;

2. an unmarried child of either the Insured named in Schedule A of the certificate or that Insured's legal spouse, who is:

   a. less than nineteen (19) years old;

   b. less than twenty-four (24) years old and in regular full-time attendance at any college or university accredited as an institution of higher learning. "Full-time attendance" shall mean twelve (12) credit hours per semester; or

   c. medically certified as disabled and dependent upon the Insured named in Schedule A of the certificate, regardless of age.

"Spouse" includes a domestic partner or participant in a civil union if the relationship is legally recognized in Your state or jurisdiction of residence.

"Child" includes a natural child, a legally adopted child, or a child placed for adoption with the Insured named in Schedule A of the certificate on or after its Effective Date. "Child" also includes a minor grandchild, niece, or nephew who is under the primary care of the Insured named in Schedule A of the certificate, if the legal guardian of the child other than the Insured named in Schedule A of the certificate is not covered by an accident and sickness plan. "Primary care" means the provision of food, clothing, and shelter on a regular and continuous basis during the time that public school is in regular session.

K. "ELIGIBLE EXPENSES" are those benefits contained in the Group Policy and described in the certificate. Services and materials will be considered Eligible Expenses only to the extent that:

1. expenses do not exceed the Usual and Customary Charges;

2. expenses are incurred while Your coverage is in force under the Group Policy; and

3. services and materials are Medically Necessary and are furnished at the direction of or under the supervision of a Physician.

L. "HOME HEALTH CARE" means care which is provided by a public or private agency that specializes in giving nursing and other therapeutic services in Your home or place of residence. The agency must be licensed as such or, if no license is required, approved by a state department or agency having authority over Home Health Care.

M. "HOSPICE CARE" means treatment provided by a public agency or private organization which meets all of the following requirements:

1. is primarily engaged in providing care to terminally ill patients;

2. provides twenty-four (24) hour care to control the symptoms associated with terminal Sickness;

3. has on its staff an interdisciplinary team which includes at least one (1) Physician, one (1) registered nurse (RN), one (1) social worker, and at least one (1) pastoral or other counselor, and volunteers;

4. is a licensed organization whose standards of care meet those of the National Hospice Organization;

5. maintains central clinical records on all patients;

6. provides appropriate methods of dispensing drugs and medicines; and

7. offers a coordinated program of home care and inpatient care for a terminally ill patient and the patient's family.

The term "Hospice" does not include any organization or part thereof which is primarily engaged in providing custodial care, or care for drug abusers, drug addicts, alcohol abusers, or alcoholics, or domestic services, a place of rest, a place for the aged, or a hotel or similar institution.

N. "HOSPITAL" means only an institution which meets the following requirements:

1. is an institution operated pursuant to law; and

2. is primarily engaged in providing or operating - either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under supervision of a staff of one (1) or more duly licensed Physicians - medical, diagnostic and surgical

facilities for medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

3. provides twenty-four (24) hour nursing service by or under the supervision of registered nurses (RNs).

The term "Hospital" also means ambulatory surgical center, provided that any services performed therein would have been covered under the terms of the Group Policy as an eligible inpatient service.

This definition shall not include an institution, or that part of an institution, operating primarily:

1. as a convalescent home, rest, nursing, or convalescent facility; or

2. as a facility affording custodial or educational care, or a facility for the aged; or

3. as a military Hospital, veterans' Hospital, or soldiers' home or any institution contracted for or operated by the federal government or any agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered where a legal liability exists for charges made to the individual for such services.

O. "INJURY" means bodily harm caused by an Accident, directly and independently of all other causes. The Injury must occur while Your coverage is in force.

P. "INSURED" means the Association member named in Schedule A of the certificate and all covered Eligible Dependents.

Q. "INTOXICATED/INTOXICATION" means a level of blood alcohol content that is specified in the laws defining Intoxication in the state where the loss or cause of loss occurred.

R. "LIFETIME MAXIMUM" means the maximum amount of Eligible Expenses that will be covered under the Group Policy for all claims submitted by the Insured named in Schedule A of the certificate and his or her covered Eligible Dependents, after which coverage for that Insured and his or her Eligible Dependents will become null and void. The Lifetime Maximum is shown in Schedule A.

S. "MANIFESTS/MANIFESTED" means that a condition is active and that there is a distinct symptom (or symptoms) from which a Physician could diagnose the condition with reasonable accuracy or when a symptom (or symptoms) is of sufficient severity to cause a person to seek medical diagnosis or treatment.

T. "MEDICAL EMERGENCY" means the sudden onset or sudden worsening of a medical condition which is evidenced by symptoms of such severity, including severe pain, that a failure to immediately provide medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

1. placing the patient's mental or physical health in serious jeopardy;

2. serious impairment to bodily functions;

3. serious dysfunction of any bodily organ or part;

4. serious disfigurement; or

5. in the case of a pregnant woman, serious jeopardy to the health of a fetus.

U. "MEDICALLY NECESSARY" means a service or supply which is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on current generally accepted medical practice. A service or supply will not be considered as Medically Necessary if:

1. it is provided only as a convenience to You or a health care provider;

2. it is not appropriate treatment for Your diagnosis or symptoms;

3. it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or

4. it is part of a plan of treatment that is experimental, unproven or related to a research protocol, in the sense that its effectiveness is not generally recognized by the medical community.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

V. "MEDICAID" means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

W. "MEDICARE" means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

X. "MENTAL OR EMOTIONAL DISORDER" means a neurosis, psychoneurosis, psychosis, or a mental or emotional disease or disorder of any kind as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

Y. "NETWORK PROVIDER" means any Hospital, Physician or other provider of medical services that has contracted with Preferred Provider Networks to furnish such services at discounted rates to the Company's Insureds. A provider who has terminated his/her contract with the Preferred Provider Network is not a "Network Provider".

Z. "NON-NETWORK PROVIDER" means any Hospital, Physician, or other provider of medical services that does not have a contract to provide services at discounted rates to the Company's Insureds through a Preferred Provider Network.

AA. "PHYSICIAN" means a duly licensed Doctor of Medicine, Osteopath, Podiatrist, Chiropractor, Midwife, Nurse Anesthetist, Psychologist or any other health care practitioner providing a covered service and acting within the scope of his or her license who is required to be recognized by any law applicable to health insurance in the state where the service is provided. The term "Physician" does not include the Insured or an Insured's close relative - spouse, domestic partner, parent, sister, sister-in-law, brother, brother-in-law, aunt, uncle, grandparent, niece, nephew, child or cousin - or an individual residing in an Insured's household.

BB. "PRE-CERTIFICATION/PRE-CERTIFIED" means the process described in Part I of the Group Policy and the certificate whereby Our Utilization Services Division reviews a proposed non-emergency Hospital confinement, outpatient surgical procedure or emergency Hospital confinement for medical necessity and appropriateness.

CC. "PRE-EXISTING CONDITION" means the existence of symptoms which would cause a person to seek diagnosis, care or treatment within the twelve (12) month period preceding the Effective Date of coverage under the Group Policy;

OR

a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within the twelve (12) month period preceding the Effective Date of coverage under the Group Policy.

DD. "SCHEDULE A" means the schedule found on page 3.

EE. "SICKNESS" means an illness or disease which first Manifests itself after the Effective Date of Your coverage under the Group Policy and while such coverage is in force. Sickness includes congenital illnesses or defects in newborn Eligible Dependents or children placed for adoption with the Insured named in Schedule A of the certificate on or after its Effective Date.

Sickness also includes Complications of Pregnancy which occur after Your Effective Date of coverage under the Group Policy. Sickness does not include normal pregnancy.

FF. "TOTALLY DISABLED/TOTAL DISABILITY" means:

1. with respect to the Insured named in Schedule A of the certificate, or a covered spouse or domestic partner, that he or she is unable to perform, by reason of Injury or Sickness, the material and substantial duties of his or her occupation and is under the regular care and attendance of a Physician for the condition causing the Total Disability;

2. with respect to an Eligible Dependent, other than a covered spouse or domestic partner, that he or she is prevented, by reason of Injury or Sickness, from engaging in the normal and customary duties and activities of a person of like age and sex, and is under the regular care and attendance of a Physician for the condition causing the Total Disability.

GG. "USUAL AND CUSTOMARY CHARGES" means:

1. For services provided by Network Providers: the contracted rate in effect for that Network Provider on the date that the service is provided to an Insured; or

2. For services provided by a Non-Network Provider: charges for medical services or supplies which are in an amount not exceeding the normal rates charged for the same or similar services or supplies in the geographic region where the service or supply is furnished. Geographic region is a zip code, city, county, or such area as is necessary to obtain a representative cross section of medical and Hospital costs.

HH. "WE", "US", or "OUR" means the National Health Insurance Company. Also referred to as the "Company".

II. "YOU" and "YOUR" means all Insureds.

PART VI - ELIGIBILITY PROVISIONS

A. ELIGIBILITY AND EFFECTIVE DATE

1. EFFECTIVE DATE

   Persons who apply for this coverage must provide evidence of insurability satisfactory to the Company in order for the Company to issue coverage. The Effective Date is shown in Schedule A of the certificate for all applicants listed on the original application for

insurance. The Effective Date for Eligible Dependents who apply for coverage at a later date will be the first day of the month following the date on which the Company approves the Eligible Dependent's insurability, except for newborns and adoptees as provided in the following paragraphs.

2. NEWBORN CHILDREN

   If a child is born to the Insured named in Schedule A of the certificate on or after the Effective Date of the certificate, the child will be immediately covered under the Group Policy as of the moment of birth. This automatic coverage will cease at the end of ninety (90) days. To continue coverage beyond the ninety (90) day period, You must notify Us in writing at the address shown on page 1 of the certificate prior to the end of the automatic coverage, of Your desire to add the child permanently to Your coverage. Any premium due for the continued coverage must also be submitted within the ninety (90) day period. A Pre-Existing Condition exclusion period will not be applied to the newborn.

3. ADOPTED CHILDREN

   Any minor child under the charge, care and control of the Insured named in Schedule A of the certificate whom the Insured has filed a petition to adopt on or after the Effective Date of the certificate will be immediately covered under the Group Policy. Coverage will begin on the date of the filing of a petition for adoption if the Insured applies for coverage within sixty (60) days after the filing of such petition for adoption. For a newborn adoptee, coverage will begin from the moment of birth if the petition for adoption and application for coverage are filed within sixty (60) days after the child's birth. A Pre-Existing Condition exclusion period will not be applied to the adoptee. Coverage for any prospective adoptee will cease upon termination of the application for adoption.

B. TERMINATION OF INSURANCE

1. Coverage for the Insured named in Schedule A of the certificate will terminate upon the earliest of:

   a. the date on which the required premium is not paid, subject to the "Grace Period" provision in Part VIII of the Group Policy and certificate;

   b. the date on which the Insured ceases to be a member of the Association to which the Group Policy is issued;

   c. the death of the Insured;

   d. the date on which You perform an act or practice that constitutes fraud or make an intentional misrepresentation of material fact under the terms of the Group Policy; or

   e. the date on which the Group Policy or all individual health insurance coverage as defined by Public Law 104-191 is terminated in Your state in accordance with Public Law 104-191 and any applicable state law.

2. Coverage for an Eligible Dependent will cease on the earliest of:

   a. the date on which coverage for the Insured named in Schedule A of the certificate terminates as described in paragraph one of this section; or

   b. the last day of the premium month in which a dependent ceases to meet the definition of an Eligible Dependent.

If an identifiable premium is accepted after the termination date for an Eligible Dependent, coverage for that dependent will continue in force until the end of the period for which premium has been paid.

C. CONTINUATION OF COVERAGE

1. TERMINATION OF EMPLOYMENT OR MEMBERSHIP: Any Insured whose coverage under the Group Policy would otherwise terminate due to termination of employment or membership in the Association may continue coverage under the Group Policy as provided herein. To have the right to continue coverage, the Insured must have been covered under the Group Policy, or any it replaced, for at least three (3) months prior to the date coverage would terminate.

   Continuation of coverage shall not be available to an Insured who is eligible for full coverage under any other group coverage, including coverage for any Pre-Existing Conditions the Insured may have.

   An Insured who wishes to continue coverage must submit a written request for continuation to Us within ten (10) days after the termination of employment or membership.

   An Insured who requests continuation of coverage must pay the premium required on a monthly basis in advance, subject to the provisions of Part VIII.A. of the Group Policy and certificate.

   Continuation of coverage shall end upon the earliest of:

   a. one hundred twenty (120) days after continuation of coverage began;

   b. the date on which the required premium is not paid, subject to the "Grace Period" provision in Part VIII.A. of the Group Policy and certificate; or

   c. the date the Group Policy terminates.

   At the termination of the continued coverage, the Insured shall be eligible for a conversion policy, subject to the provisions of Part VI.E. "Medical Benefits Conversion Right".

2. LOSS OF ELIGIBILITY AS AN ELIGIBLE DEPENDENT: If an Eligible Dependent's coverage terminates as set forth in paragraph B.2., of this Part VI of the Group Policy and certificate, due to reaching the limiting age or a change in marital status, the Eligible Dependent may continue coverage without providing evidence of insurability by making the required premium payments for issuance of his or her own certificate and by becoming a dues paying member of the Association to which the Group Policy is issued. The Eligible Dependent must submit a written request for this continuation of coverage within thirty-one (31) days of the date on which coverage would otherwise terminate.

D. EFFECT OF MENTAL OR PHYSICAL HANDICAP ON TERMINATION

An unmarried Eligible Dependent's insurance may be kept in force past the date it would have ended due to age if:

1. prior to reaching that age, the Eligible Dependent is not able to earn a living due to mental or physical handicap; and

2. the Eligible Dependent remains dependent on the Insured named in Schedule A of the certificate for the majority of his or her support.

As evidence that the handicap still exists, written proof will be required, but not more often than once a year. The proof must be submitted in a form required by the Company. The handicap will be considered to have ceased if the required proof is not received when due. Otherwise, insurance of the Eligible Dependent will end when:

1. the handicap ceases; or

2. it would end for reasons other than the Eligible Dependent's age.

E. MEDICAL BENEFITS CONVERSION RIGHT

1. NATURE OF THE CONVERSION RIGHT: This right applies if You lose coverage under the Group Policy except as specified herein. You may convert, without providing evidence of insurability, to a Guaranteed Renewable Conversion Policy offering similar coverage. This right is subject to the terms of this section.

   The premium rate for the conversion policy will be based on Your current age under the converted certificate.

   You may not convert if benefits under the Group Policy cease because:

   a. premium contributions were not paid when due;

   b. benefits are replaced by similar group coverage within thirty-one (31) days; or

   c. termination of coverage is due to a complete withdrawal by the Company from the individual market in the state as allowed under state and federal law.

   To convert, You must submit the following within thirty-one (31) days of termination of coverage:

   a. written application; and

   b. the first premium payment.

2. PERSONS COVERED UNDER A CONVERSION POLICY: Any Insured who was covered under the certificate on the date of termination.

   At Our option, a separate conversion policy will be issued to each Eligible Dependent.

3. FORM OF THE CONVERSION POLICY: The conversion policy will be on a form that is allowed in the state in which it is issued.

   The benefit level of the conversion policy will not exceed the benefit level of the certificate at the time of termination. Benefit levels will take into account:

   a. stated dollar amounts;

   b. co-insurance percentages;

   c. established maximums; and

   d. deductibles.

4. EFFECTIVE DATE OF THE CONVERSION POLICY: The conversion policy will take effect on the day following termination of eligibility for medical benefits under the Group Policy.

5. PREMIUM MODE: The initial conversion premium must be quarterly.

F. EXTENSION OF MEDICAL BENEFITS

If You are Totally Disabled at the time insurance terminates, Your coverage will continue during such Total Disability but only for the bodily Injury or Sickness causing the disability. The maximum period for such coverage is the earlier of the following:

1. the date on which You cease to be Totally Disabled;

2. three (3) months after the date on which insurance coverage would otherwise have terminated; or

3. the date on which You acquire insurance under a replacement plan which provides similar benefits but only if the plan covers the Injury or Sickness causing the disability without limitation.

If You are Hospital confined at the time insurance terminates, coverage will continue until Your Hospital confinement ends or benefits are exhausted, whichever is earlier.

G. MEDICARE ENROLLMENT

If You become enrolled in Medicare at the same time that Your coverage under the Group Policy is in force, continued coverage will be provided only to the extent that the benefits payable by the Group Policy are not also reimbursed by Your Medicare coverage. Your premium rate will be revised for this change in coverage as of the first premium due date after We receive written notice of Your Medicare enrollment.

If in the future, Public Law 104-191 is amended to allow termination of Your coverage upon enrollment in Medicare, We will have the option to take such action.

H. CANCELLATION BY THE INSURED

You may cancel Your coverage under the Group Policy by sending Us a written request. In this event, Your certificate will terminate on the first premium due date following the date We receive Your written request in Our Home Office, and Your coverage will not remain in effect during the grace period described in Part VIII of the Group Policy and certificate. Our liability for a premium refund will be limited to any premium payment We accept or draft from Your bank account in error after the date We receive Your written request to cancel Your coverage. You may not cancel Your coverage in advance of a premium due date to receive a refund of unearned premiums, unless otherwise allowed by the laws of Your state.

PART VII - GENERAL CONTRACT PROVISIONS

A. ENTIRE CONTRACT: The Group Policy (with the application, Your enrollment form, and all attached options and amendments) is the entire contract between the Group Policyholder, You and Us. Any statement made by You, in the absence of fraud, will be considered a representation and not a warranty. After Your certificate has been in force for two (2) consecutive years, any statements, except fraudulent misstatements, made in Your application will not be used to void the certificate. Any statement which You make for the purpose of effecting insurance may not be used to void Your coverage or reduce Your benefits unless it is contained in a written statement signed by You or the primary Insured, a copy of which has been furnished to You or Your beneficiary.

No changes in the Group Policy or the certificate shall be valid unless approved by an executive officer of the Company and such approval be endorsed thereon or attached thereto. No agent has the authority to change the Group Policy or the certificate or to waive any of their provisions.

B. INDIVIDUAL CERTIFICATES: A certificate will be issued to the Insured named in Schedule A of the certificate that describes the provisions of the Group Policy and where the Group Policy may be inspected.

C. CONFORMITY WITH STATE STATUTES: Any provisions of the certificate that are in conflict with the statutes of the state which governs this coverage will be changed or deemed to conform with the minimum requirements of such laws as of the time such laws should or would have been effective as to the certificate.

D. WAIVER OF RIGHTS: If any provision of the Group Policy or the certificate is not enforced, such failure will not affect Our right to do so at a later date, nor will it affect Our right to enforce any other provision of the Group Policy or the certificate.

E. OTHER INSURANCE WITH THIS INSURER: Insurance effective at any one time on You under a like group or individual policy in this Company is limited to the one such policy elected by You, Your beneficiary, or Your estate, as the case may be. All premiums paid on all other such policies from the time the duplication of coverage existed will be returned without interest.

PART VIII - PREMIUM PROVISIONS

A. GRACE PERIOD: After payment of the first premium, a grace period of thirty-one (31) days following a premium due date will be allowed to pay subsequent premiums. During the grace period, Your certificate will remain in force unless written notice is received from You prior to the end of the grace period that the coverage is to be terminated. If You do not pay the premium prior to the expiration of the thirty-one (31) day period from the due date, the certificate will lapse due to non-payment of premium and coverage will cease at 12:00 p.m. on the thirty-first (31st) day. You will be liable for payment of the premium for the period that the coverage remains in force if benefits are paid for Eligible Expenses incurred during the grace period. Such payment will not extend coverage beyond the grace period.

B. REINSTATEMENT: If Your certificate lapses due to non-payment of premium, reinstatement of Your coverage may be considered if You notify Us of Your intention to reinstate. Upon such notice, We will furnish You an application to be completed and submitted along with premiums necessary to pay the certificate to a current status. Your premium payment and Your completed application for reinstatement must be received at Our Home Office at the address shown on page 1 within ninety (90) days after the last day for which premium payment was made. Reinstatement will not be effective unless approved by the Company. At Our option, the approved reinstatement may not include coverage during the lapsed period and premiums would not be charged for this period.

C. MISSTATEMENT OF AGE OR SEX: If Your age or sex has been misstated, there shall be an adjustment of the premium for the certificate, retroactive to Your Effective Date, so that there shall be paid to Us the premium for the coverage at the correct age and sex. The amount of the insurance coverage shall not be affected. Continuation of coverage shall be contingent upon payment of all premium in arrears. Any overpayment of premium by You will be promptly refunded.

D. PREMIUM CHANGES: Your premium rate can be changed at any time by giving thirty-one (31) days written notice to You. Written notice shall be considered effective when We address the notice to Your last known mailing address and deposit the notice, postage paid, into the care and custody of the United States Postal Service. You cannot be singled out for renewal rate increases due to claim loss experience on Your individual certificate.

PART IX - CLAIM PROVISIONS

A. NOTICE OF CLAIM: Written notice of claim must be given to Us within thirty (30) days after the occurrence or commencement of any loss covered by the Group Policy, or as soon thereafter as is reasonably possible. Notice given by You or on Your behalf to Our Home Office with information sufficient to identify You, shall be deemed notice to Us.

B. CLAIM FORMS: When notice of claim is received, You will be sent forms for filing Your claim. If these forms are not given to You at Your last known address within fifteen (15) days, You can meet Our requirements by giving Us a written statement. This statement should include the nature and extent of the claim and be sent to Us within the time stated in the "Proof of Loss" provision. Where claims are incurred by a non-insuring parent of a child covered under the Group Policy, claim forms and any other necessary information will be provided for the non-insuring parent to obtain benefits.

C. PROOF OF LOSS: You must furnish Us acceptable written proof of loss within ninety (90) days of Your claim. If it was not possible for You to give proof within the ninety (90) days, Your claim will not be denied for this reason if You send the proof as soon as You can. In any event, You must send Us the proof no later than one (1) year from the time specified, unless You are legally incapacitated.

D. TIME OF PAYMENT OF CLAIMS: Payments for a covered claim will be made to You as they are incurred, within the time frames required by law in Your state of residence.

E. PAYMENT OF CLAIMS: All payments will be made to You, unless You direct otherwise in writing or except as provided herein. Any unpaid claim at Your death may, at Our option, be paid to Your beneficiary or estate. Where covered expenses are incurred by a non-insuring parent of a child that is covered under the Group Policy, benefits will be payable, as appropriate, to the non-insuring parent, a health care provider, or a state or federal agency when required by law.

F. PHYSICAL EXAMINATIONS AND AUTOPSY: We have a right to have You examined, at Our expense, as often as reasonably necessary while a claim is pending. In case of death, We may also have an autopsy performed unless prohibited by law.

G. CLAIMS APPEAL: If Your claim is denied in whole or in part, You will be notified in writing. Within sixty (60) days of receiving this notification, You may request that any portion of the claim for which You believe benefits were wrongly denied be reconsidered. Your request for reconsideration must be in writing, and must include:

1. the name and address of the Insured named in Schedule A of the certificate and the patient;

2. the Certificate Number;

3. the date(s) of service;

4. the claim number from the decline notice;

5. the provider's name; and

6. the reason why the claim should be reconsidered.

You may, within forty-five (45) days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. Written releases may be required, if it is determined that the information is sensitive or confidential. You may also, within forty-five (45) days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

A written decision will be provided to You within sixty (60) days after Your request for review has been received. That written decision will indicate the reasons for the decision and refer to the Group Policy provision(s) on which it was based. In special circumstances, additional time may be necessary to make a decision. You will be informed if this happens but it will never be more than one hundred twenty (120) days from the date of the original declination.

After You receive Our decision and if You disagree with the decision, You may request External Review as described in the following paragraph or arbitration as described in Part X of the Group Policy and certificate.

These claims appeal procedures also apply to any Utilization Review decision which is made as described in Part I of the Group Policy and certificate.

H. RIGHT TO EXTERNAL REVIEW: Within sixty (60) days after the date of receipt of a notice of an Adverse Determination or Final Adverse Determination, You may file a request for an external review with Us.

All requests for external review must be made in writing to National Health Insurance Company at 1901 N. State Highway 360, Grand Prairie, Texas 75050 or Post Office Box 619999, Dallas, Texas 75261-6199.

A request for an external review may not be made until You have exhausted Our Claims Appeal procedure.

An external review decision is binding on both You and Us except to the extent either of Us have other remedies available under applicable federal or state law.

Except in the case of a request for an expedited external review, at the time of filing a request for external review, You must submit to the independent review organization a filing fee of twenty-five dollars ($25.00) along with the information and documentation to be used by the independent review organization in conducting the external review. Upon application by You, the commissioner may waive the filing fee upon a showing of undue financial hardship. The filing fee will be refunded to the person who paid the fee if the external review results in the reversal, in whole or in part, of Our Adverse Determination or Final Adverse Determination that was the subject of the external review. If a request for a standard external review or an expedited external review is filed against Us, We will pay the cost of the independent review organization for conducting the external review and will not charge back the cost of the external review to a health care provider.

You have the right to contact the Commissioner of Insurance for assistance at any time by phoning (800) 224-6330, e-mailing Insurance.Administration@mail.state.ar.us, or writing to 1200 West Third Street, Little Rock, Arkansas 72201-1904.

When filing a request for an external review, You will be required to authorize the release of any of Your medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Notice related to an Adverse Determination: You may file a request for an expedited external review at the same time You file a request for an expedited review of an appeal as set forth in Our internal grievance procedure or utilization procedure if:

1. You have a medical condition where the timeframe for completion of an expedited review of an appeal set forth in Our internal grievance procedure or utilization review procedure would seriously jeopardize Your life or health or Your ability to regain maximum function; or

2. the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is "experimental" or

"investigational", and Your treating Physician certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

The independent review organization conducting the external review will determine whether You will be required to complete Our expedited internal grievance procedure or utilization review procedure before it conducts the expedited external review.

If You file an appeal under Our internal grievance procedure or utilization review procedure, and if We have not issued a written decision to You within thirty (30) days following the date You file the appeal with Us for a Pre-Certification claim or within sixty (60) days following the date You file the appeal with Us for a non-Pre-Certification claim, and You have not requested or agreed to the delay, You may file a request for external review and will be considered to have exhausted Our internal grievance procedure or utilization review procedure.

Notice related to a Final Adverse Determination: You may file a request for an expedited external review if:

1. You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function; or

2. if the Final Adverse Determination concerns an admission, availability of care, continued stay or health care service for which You received emergency services, but have not been discharged from the facility; or

3. a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, and Your treating Physician certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested health care service or treatment that is the subject of the requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

"Adverse Determination" means a determination by Us that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because the requested health care service does not meet Our requirements for medical necessity, or the requested health care services have been found to be "experimental/investigational".

In order to qualify as an "Adverse Determination" for purposes of external review, the decision must involve treatment, services, equipment, supplies, or drugs that would require Us to expend five hundred dollars ($500.00) or more.

"Adverse Determination" does not include a determination by Us to deny a health care service based upon:

1. an express exclusion in the health benefit plan other than a general exclusion for "medical necessity" or "experimental/investigational";

2. an express limitation in the health benefit plan with respect to the number of visits, treatments, supplies or services for a covered benefit in a given calendar period or over Your lifetime;

3. an express limitation in the health benefit plan with respect to a maximum dollar limitation with respect to a covered benefit in a given calendar period or over Your lifetime;

4. a determination by Us that You are not eligible to be a covered person;

5. a determination by Us that treatment, service, or supplies were requested or obtained by You through fraud or material misrepresentation;

6. the health benefit plan's procedure for determining Your access to a health care provider;

7. illegality of services or the means or methods of administering them;

8. FDA or other government agency determinations, reports, or statements; or

9. licensure, permit or accreditation status of a health care provider.

"Final Adverse Determination" means an Adverse Determination involving a covered benefit that has been upheld by Us at the completion of Our internal grievance procedure or utilization review procedure.

PART X - ARBITRATION OF CLAIM DISPUTES

Any dispute regarding claims processing or administration that has not been resolved after the procedures described in the "Claims Appeal" section of Part IX of the Group Policy and certificate have been followed, shall be resolved through non-binding arbitration. Such arbitration shall be administered under the rules of the American Arbitration Association (AAA). One (1) arbitrator shall decide the dispute, unless all parties agree to have three (3) arbitrators. Unless otherwise agreed by all parties, any arbitrator must be a licensed attorney who has practiced life, health and accident insurance law for at least five (5) years. Unless otherwise agreed by all parties, the arbitrator(s) shall be appointed from a list of qualified persons provided by AAA. Any court having proper jurisdiction over all parties may render judgment based upon the award of the arbitrator(s). All fees and expenses of the arbitration shall be paid by the parties equally, except that each party shall pay the cost of its own attorney, experts, witnesses and the preparation and presentation of its proof. The Federal Arbitration Act shall govern the arbitration. Such arbitration shall be a condition precedent to legal action by the Insured or the Company.

All aspects of the arbitration are confidential. Neither a party, an attorney for a party nor an arbitrator may disclose the evidence, content or results of the arbitration without the prior written consent of all parties.

PART XI - APPEAL AND ARBITRATION OF OTHER DISPUTES

Complaints and disputes other than those involving claims processing or administration will first be handled under the same general procedures as those set forth under Part IX of the Group Policy and certificate regarding "Claims Appeal". If this process does not resolve the complaint or dispute, then the matter will be resolved by non-binding arbitration under the same terms as provided under Part X of the Group Policy and certificate regarding "Arbitration of Claim Disputes".

PART XII - COORDINATION OF BENEFITS (COB)

A. COORDINATION OF BENEFITS: You may have other medical expense coverage in addition to this coverage. If so, the benefits from the "Other Plan" will be considered when Your claim is paid. This may require a reduction of benefits under this coverage so that the combined benefits will not be more than one hundred percent (100%) of Your "Allowable Expenses".

B. ORDER OF COORDINATION: To determine whether Our benefits will be reduced, the order in which the various plans will pay benefits has to be determined. This will be done as follows:

1. a plan with no provision to coordinate with other plans will be considered to pay its benefits before a plan which has such a provision;

2. a motor vehicle accident policy will be considered to pay its benefits before other plans for expenses incurred as a result of a motor vehicle accident;

3. a plan which covers You other than as a dependent will be considered to pay its benefits before a plan which covers You as a dependent;

4. a plan which covers You as a dependent of a person whose birthday occurs earlier in the year will be considered to pay its benefits before a plan which covers You as a dependent of a person whose birthday occurs later in the year; except in the case of separation or divorce, the following rules will apply:

    a. the plan of the parent with custody, who is not remarried, will be considered before the parent without custody;

    b. if the parent is remarried, and has custody of the child, the plan of the step-parent will be considered before the plan of the parent without custody;

    c. if there is a court decree which established financial responsibility for medical or health care expenses with respect to dependent children, the benefits of the plan of the parent with financial responsibility shall be considered before the benefits of any other plan;

5. the primary plan of a retired or laid-off employee who is covered by two (2) employers will be the plan which covers him/her as an active full-time employee; and

6. if 1, 2, 3, 4, or 5 above do not establish the order of payment, the plan under which You have been covered the longest will pay its benefits first. The date You first became a covered member of the group will be used as the oldest date of coverage.

C. OTHER PLAN: "Other Plan" means any other plan of medical expense coverage provided by:

1. group or blanket insurance coverage;

2. group Blue Cross, Blue Shield, other group prepayment coverage or health maintenance organization;

3. coverage under an employer sponsored self-insurance plan;

4. a motor vehicle insurance policy; and

5. coverage provided under any governmental program or required or provided by any statutes, except Medicaid or Medicare.

The term "Other Plan" will not include individual insurance or subscriber contracts, or group or blanket school accident type coverages, or hospital indemnity benefits.

D. ALLOWABLE EXPENSE: "Allowable Expense" means any usual or customary medical expense which is covered under any of the plans involved. An allowable charge to a "Secondary" plan includes the value or amount of any deductible, co-insurance percentage, or amount of

otherwise allowable expenses which were not paid by the "Primary" or first paying plan. Coordination of Benefits will not apply to claims of less than one hundred dollars ($100.00).

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION: Certain facts are needed to apply these COB rules. We may get material facts from each person claiming benefits and also gather material facts from or give them to any other insurance company or health benefit plan administrator with whom We coordinate benefits.

F. FACILITY OF PAYMENT: A payment made under another plan may include an amount which should have been paid under this plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again.

G. RIGHT TO RECOVERY: If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;

2. insurance companies; or

3. other organizations.

H. RIGHT OF SUBROGATION OR REIMBURSEMENT: Upon Our payment of any benefits under this coverage, We shall be subrogated to all of Your rights of recovery against any person or legal entity that may be liable to You, whether in contract or tort, for a claim arising out of or related to Your Injury or Sickness, but only to the extent of the benefits so provided. You shall cooperate with Us and do whatever is necessary for Us to secure Our subrogation rights and to collect Our subrogation claim. You shall not settle any such claim without Our consent or do anything to prejudice Our subrogation rights or Our efforts to collect Our subrogation claim.

As security for Your obligations to Us, You grant Us a lien on any sum of money that You may recover by settlement, judgment or otherwise, from any person or legal entity for a claim arising out of or related to Your Injury or Sickness. You agree that out of any such recovery, We shall receive the first disbursement for the amount of the benefits that We paid, regardless of whether You have been fully compensated and before payment of any other existing claims, including any claim by You for general damages. If any applicable law does not allow subrogation, You agree to reimburse Us from any such recovery for any benefits that We paid under this coverage, before applying the recovery to any other existing claim.

In the event You recover from the third party, reasonable cost of collection and attorney's fees thereof shall be assessed against You and Us in the proportion each benefits from the recovery.

NATIONAL HEALTH INSURANCE COMPANY

August 28, 2009

ELECTRONIC FILING

Honorable Jay Bradford
Commissioner of Insurance
Insurance Division
1200 West Third Street
Little Rock, AR 72201-1904

RE: **National Health Insurance Company**
NAIC#: 4669-82538

Policy Form No.:	HSMPPO-2009P - Group Hospital Surgical Medical PPO Policy
Certificate Form No.:	HSMPPO-2009 - Group Hospital Surgical Medical PPO Certificate
Rider Form No.:	RDR.POV-709 - Outpatient Physician Visit Benefit Rider
Application Form No.:	NH-1175-8/09 - Individual Application *(replaces NH-1175.1/2)*
Application Form No.:	NH-1161-8/09 - Supplement to Application *(replaces NH-1161-7/1)*

Dear Commissioner Bradford:

Enclosed for your review and approval are the above referenced forms. These are new forms and are not intended to replace existing forms except as noted above. Policy form HSMPPO-2009P is a group hospital surgical medical PPO plan which will be issued to association groups in the District of Columbia. Initial group policyholder information is attached. Coverage under the group policy is evidenced by the Certificate of Insurance, HSMPPO-2009, to be issued to association members. The policy and certificate are identical with the exception of the first three pages.

This new group policy form is substantially similar to previously filed group policy form USA+2002P except that modifications have been made to create a PPO plan instead of an Indemnity product (proof of prior filing is enclosed). Rider form RDR.POV-709 will add a benefit to all certificates issued under the group policy in order to provide coverage for physician office visits.

This product will be solicited by licensed agents, using application forms, NH-1175-8/09 and NH-1161-8/09, which will be used in both paper and electronic formats. Additionally, both these applications are intended to also be used with our existing group policy form USA+2002P (proof of prior approval enclosed).

This product will not be mass marketed. This product will not be marketed to "Small Employers" as that term is defined in your state or under federal law. We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

Thank you in advance for your time spent in the review of this filing. Please contact me if you should require any additional information.

Sincerely,

Eva A. Green, AIRC, FLMI, HIA
Vice President/Compliance Dept.
(817) 640-3410
(817) 640-3465 fax
eva.green@nhic.com

GROUP POLICYHOLDER INFORMATION
GROUP POLICY FORM HSMPPO-2009P

The National Association for Independent Business (NAIB) was originally organized under the Missouri Nonprofit Corporation Law as of June 10, 1993 and the Articles of Incorporation were amended to the current name as of December 22, 2003. NAIB has offices in Missouri, Texas, and the District of Columbia.

The Small Business Association of America (SBA) was originally incorporated under the District of Columbia Nonprofit Corporation Act on June 1, 1965 and the Articles of Incorporation were amended to the current organization name as of March 15, 1991.

United Service Association For Health Care (USAHC) was originally incorporated under the District of Columbia Nonprofit Corporation Act on April 13, 1983 and the Articles of Incorporation were amended to the current organization name as of February 12, 1988. USAHC has offices in both the District of Columbia and Texas.

Business Workers of America (BWA) was originally incorporated under the District of Columbia Nonprofit Corporation Act on October 31, 2002 and the Articles of Incorporation were amended to the current name as of June 22, 2006. BWA has offices in both the District of Columbia and Texas.